

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>2mos 5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>220 Walnut Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna E. Adams</u>				4. DATE OF DEATH Month Day Year <u>January 24 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 31, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Backwinder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Silk business</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Stafford (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Williams Stafford (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Bernard W. Adams 220 Walnut Place, Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1906</u> , 19 <u>55</u> , to <u>24 Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 Jan</u> , 19 <u>59</u> , and that death occurred at <u>12:20 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James S. Stegmaier</u> M.D. <u>122 S. Centre St., Cumberland, Md.</u> PHYSICIAN'S NAME (Type) <u>J.G. Stegmaier, M.D.</u> <u>122 S. Centre Street Cumberland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

CERTIFICATE OF DEATH

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 Item 9 FilmG238 2-6-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>22 Frostburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>			e. STREET ADDRESS <b>Davidson Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN R. ANDERSON</b>			4. DATE OF DEATH Month <b>1</b> Day <b>30</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1884</b>	9. AGE (In years last birthday) <b>74 7/5 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Brickyard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Anderson</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Hobaugh</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-2715</b>		17. INFORMANT <b>John Anderson Frostburg, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Base Skull Fracture RT</b> <b>812X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malar Bone Compound Fracture RT Femur</b> DUE TO (c) <b>Compound Fracture RT Tibia Shank</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by Automobile on Highway</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>1-30</b> a.m. <b>1-30</b> p.m. <b>1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 36</b>	20f. (City or town) <b>Frostburg Allegany Md</b>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W O McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Jan 31 1959</b>	
EXAMINER'S NAME (Type) <b>W O McLane md</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/2/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Coney Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONA CONING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER - CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 Fayette St.</b>		d. STREET ADDRESS <b>309 Fayette St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Harmon</b> <b>Brown</b> <b>Arnold</b>		4. DATE OF DEATH <b>Jan. 20</b> <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25. 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dominick Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Michael</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. John McPartland-Barton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>coronary heart disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1959</b> to <b>January 20, 1959</b> , that I last saw the deceased alive on <b>10/3</b> <b>1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>55 Greene St. Cumberland</b> DATE SIGNED <b>1/22/59</b>			
ACTUAL SIGNATURE <b>Elizabeth Briggs</b> M.D.			
PHYSICIAN'S NAME (Type) <b>E. G. BRINGS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Barton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Bral</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 3 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>43 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CLAYTON</b> Last <b>BANE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1880</b> <b>xxxxxx</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Western Maryland MARYLAND</b>	
13. FATHER'S NAME <b>HOLLAND BANE</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA LOAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. J. Clayton Bane</b>				1063 National Highway <b>La Vale, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Prostate</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>16 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>29 Nov., 1958</b> , to <b>11 Jan., 1959</b> , that I last saw the deceased alive on <b>11 Jan., 1959</b> , and that death occurred at <b>10:55 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>132 So Centre St, Cumberland Md</b> DATE SIGNED <b>12 Jan 59</b>							
ACTUAL SIGNATURE <b>James S. Stegmaier</b>				PHYSICIAN'S NAME (Type) <b>JAMES G. STEGMAIER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

WILLIAM STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

DATE OF DEATH: 11-11-1911

TIME: 11:00 AM

AGE: 45

SEX: Male

RACE: White

EDUCATION: High School

RELIGION: Catholic

PLACE OF BIRTH: New York City

CAUSE OF DEATH: Heart Disease

PLACE OF DEATH: Home

DATE OF BURIAL: 11-13-1911

PLACE OF BURIAL: St. Mary's Church

NAME OF MINISTER: Rev. J. J. Smith

NAME OF FUNERAL HOME: J. J. Smith

NAME OF UNDERTAKER: J. J. Smith

NAME OF CEMETERY: St. Mary's Cemetery

NAME OF INTERVIEWER: J. J. Smith



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G238 1-23-59 et

Reg. Dist. No.

00006

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>4</b></span>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>			d. STREET ADDRESS <b>610 HILL TOP DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CALVIN</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 59</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 28, 1879</b>		9. AGE (In years last birthday) <b>79 78</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heater-Rolling Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA, #Sharon</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>CHRISTOPHER BASHER</b>			14. MOTHER'S MAIDEN NAME <b>CATHERINE ERNST</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis with Occlusion and Cardiac Hypertrophy, Marked</b> DUE TO (c) <b>--</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of Left Hip</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>Fell at home in his bedroom</b>			
20c. TIME OF INJURY Month, Day, Year <b>6:00 Jan. 15 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Cumberland, Alleg. Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>Benedict Skitarelic, Md D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>I-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Cem.</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Scarpelli</i>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>		DATE			



## 5 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN TB <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		d. STREET ADDRESS <b>Box 237</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Bennett</b> Last <b>Bennett</b>		4 DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/02</b>
9. AGE (In years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Micha Browning</b>		14. MOTHER'S MAIDEN NAME <b>Cornelius Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Husband- Pt's chart.</b>		Address <b>Hancock Md.</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Myocarditis with Thrombosis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>21 Months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-6-59</b> to <b>1-6-59</b> , that I last saw the deceased alive on <b>1-6-59</b> , and that death occurred at <b>10:25</b> AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>169 Green St Cumberland Md</b> DATE SIGNED <b>1-6-59</b>	
ACTUAL SIGNATURE <b>J. J. Johnson</b>		PHYSICIAN'S NAME (Type) <b>M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.9.59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellow's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Flintstone Allegany Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone</b>		ADDRESS <b>Hancock Md</b>	
24a. REC'D BY REGISTRAR <b>JAN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Friend</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone</b>		c. LENGTH OF STAY IN lb <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Samuel A. Bennett</b>				4. DATE OF DEATH January 20 19 59			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1968</b>		9. AGE (In years last birthday) <b>90 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Flintstone, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George S. Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Imes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Mrs. Curtis Nash, Flintstone, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>450.0</b> DUE TO <b>End arteritis of foot</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> (c) <b>Arterio sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 5, 1939</b> to <b>Jan 20, 1959</b> , that I last saw the deceased alive on <b>Jan 19, 1959</b> , and that death occurred at <b>11 A.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Road Cumberland</b> DATE SIGNED <b>1/20/59</b> ACTUAL SIGNATURE <b>Samuel E. Enfield</b> M.D. <b>Ellerslie, Maryland</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Christian Com</b>		22d. LOCATION (City, town or county) (State) <b>Bedford County, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>J. L. Krasa</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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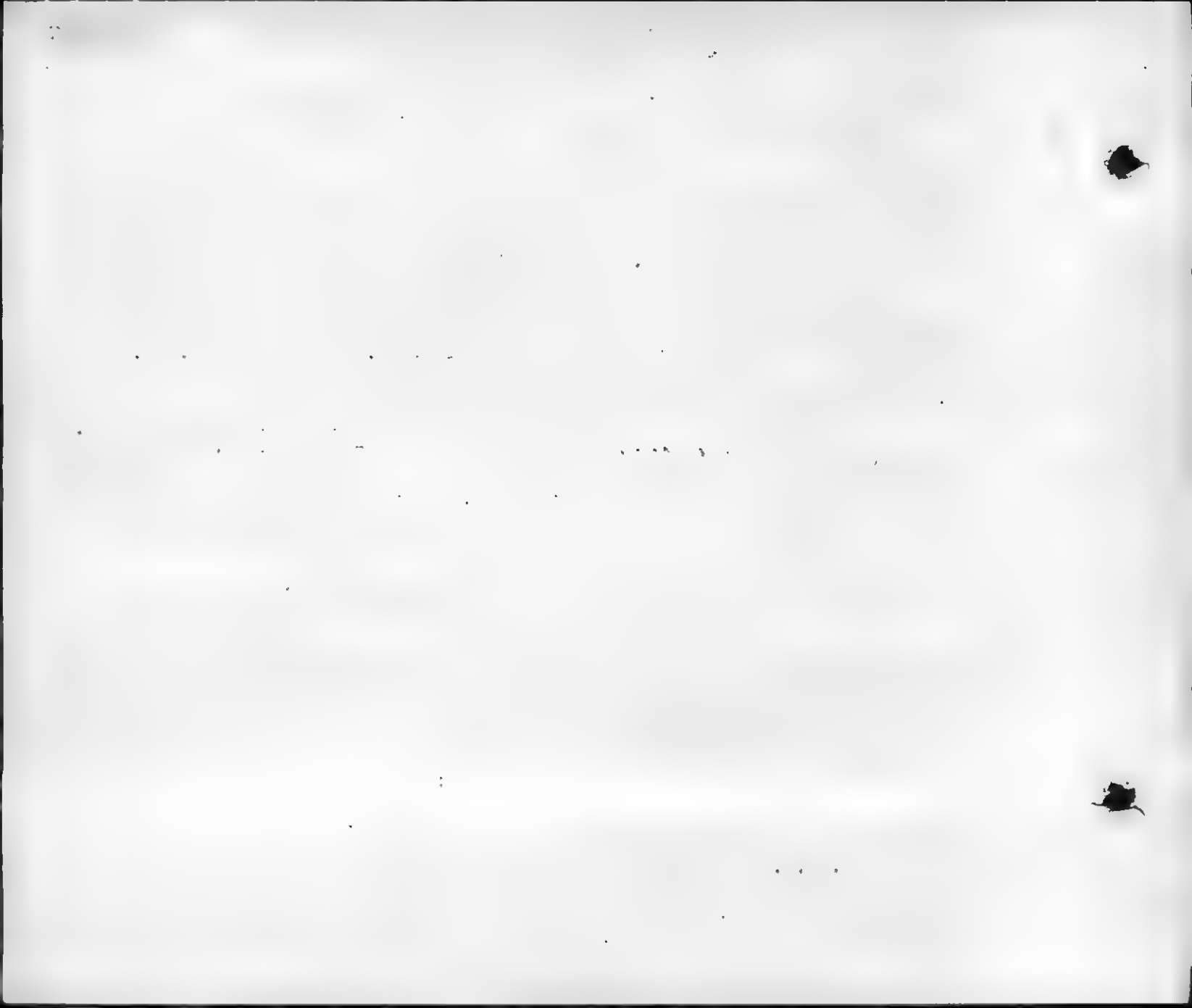
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
		d. STREET ADDRESS <b>411 PULASKI STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>MYRON</b> Middle <b>STUART</b> Last <b>BERKLEY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Food Dealer</b>	9. AGE (In years last birthday) yrs. <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>BERLIN, PA.</b>		12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEWIS BERKLEY</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-273</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVE.</b>		<b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fat advanced Cerebral Arteriosclerosis</b> DUE TO <b>Series of little strokes</b> (c) <b>Series of little strokes</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-11-1959</b> to <b>1-23-1959</b> , that I last saw the deceased alive on <b>1-22-1959</b> , and that death occurred at <b>5:00A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. J. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>1-23-59</b>	
PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Jan 25, 1959</b>	<b>Rose Hill Mausoleum</b>	<b>Cumberland Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Harper</b>		ADDRESS <b>Cumberland Md</b>	24a. REC'D BY REGISTRAR <b>DATE JAN 27 1959</b>
		24b. REGISTRAR'S SIGNATURE <b>C. J. P. [unclear]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



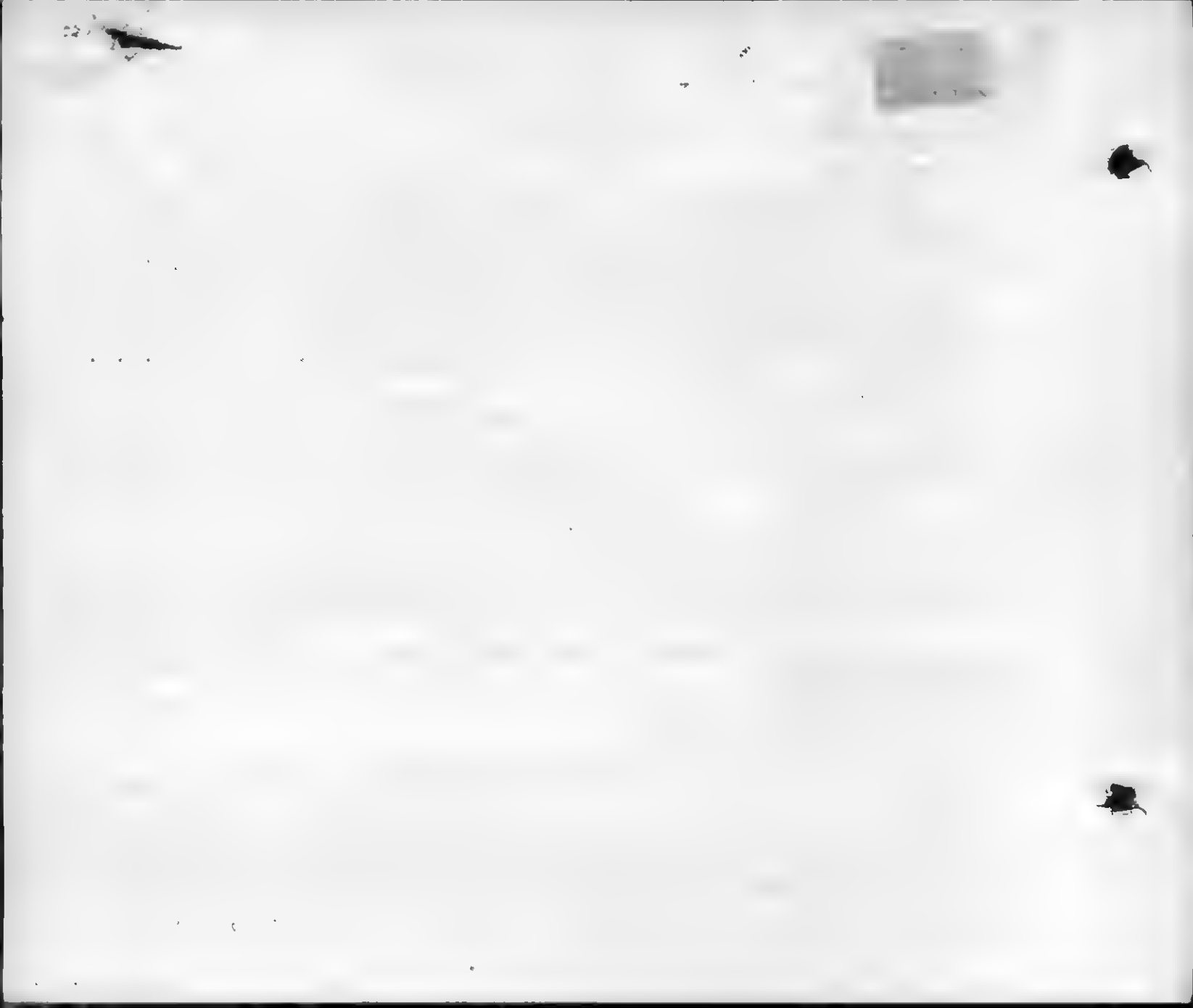
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00009

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>2 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
		f. STREET ADDRESS <b>Jackson Street</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> <b>E.</b> <b>BERRY</b>		4. DATE OF DEATH <b>Jan, 21st, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Rawlings, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Daniel De Vault</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Noel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James Berry</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b>Chronic Congestive Heart failure</b> (c) <b>Chronic Congestive Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>Jan</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 21</b> , 19 <b>59</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leslie R. Miles</b> M.D.		DATE SIGNED <b>1.23.59</b>	
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR.</b>		<b>Lonaconing Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/25/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONA CONING, MD.</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kirsch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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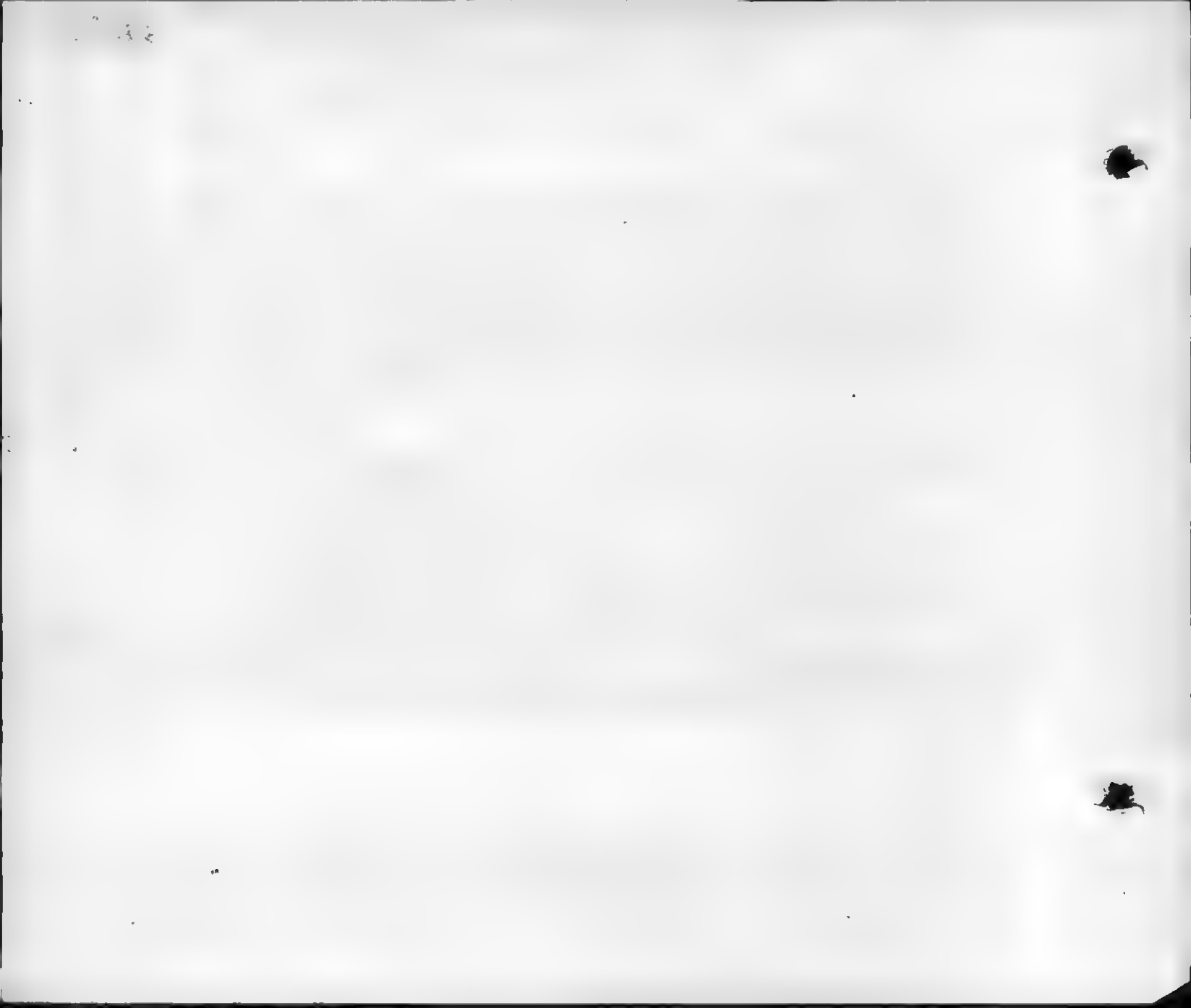
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X</u> <u>Eckhart</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>BOLINGER</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mines</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Bolinger</u>		14. MOTHER'S MAIDEN NAME <u>Anna Felchon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-6689</u>	
17. INFORMANT <u>Mrs. Anna Bolinger, Frostburg, Md. Rt. 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>151X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr -</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County) (State)	
21. I certify that I attended the deceased from <u>Nov 3, 1958</u> to <u>Jan 5, 1959</u> , that I last saw the deceased alive on <u>Jan 5, 1959</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Broadway, Frostburg, Md.</u> DATE SIGNED <u>John B. Davis, M.D.</u>			
ACTUAL SIGNATURE <u>John B. Davis, M.D.</u>		PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-8-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 8 53</u>		24b. REGISTRAR'S SIGNATURE <u>John B. Davis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

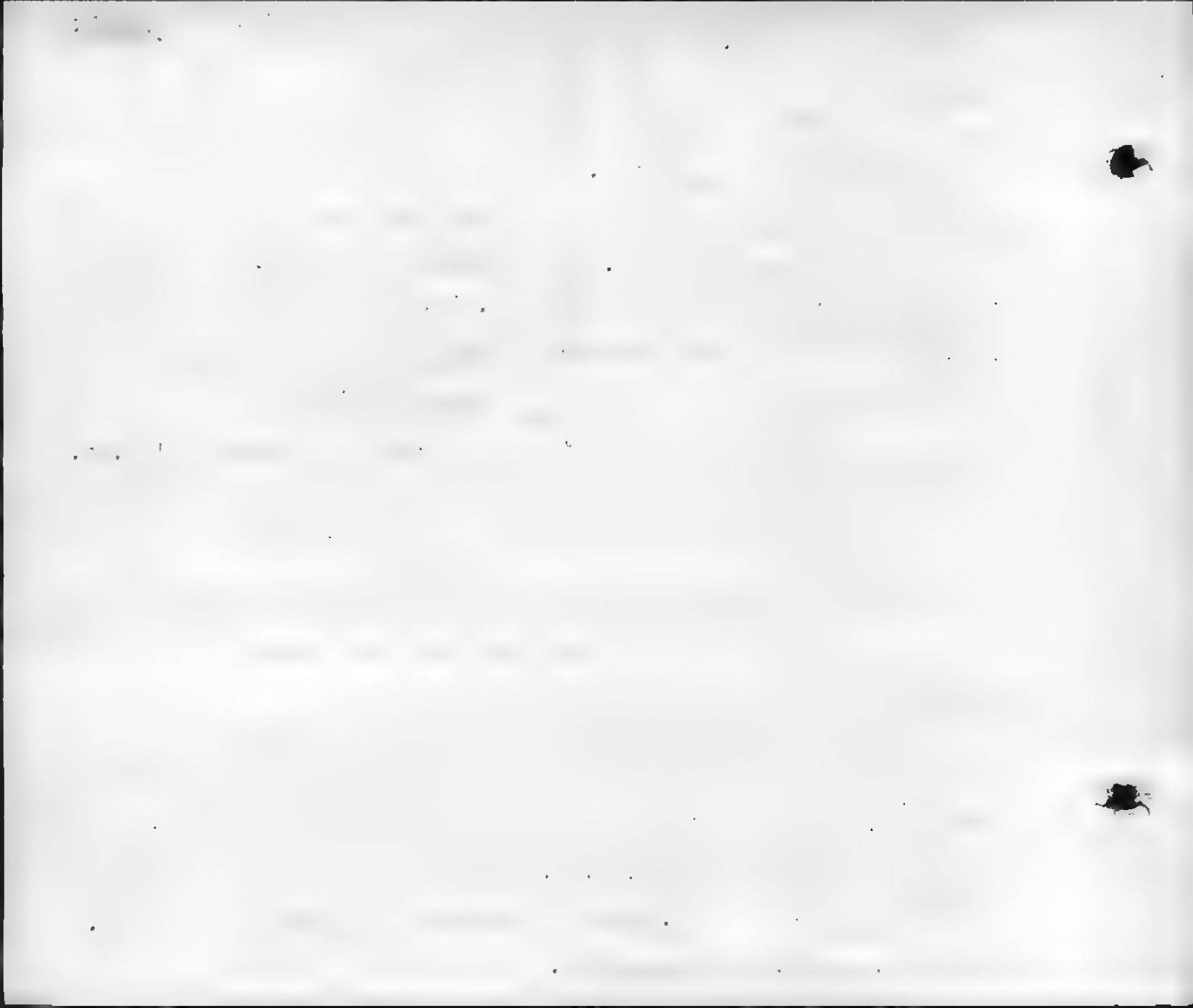


CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>	
d. NAME OF HOSP TAL (If not in hospital, give street address) OR INSTITUTION <b>48 Broadway (Own home)</b>		d. STREET ADDRESS <b>48 Broadway</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Annie M. Bruner</b>		4. DATE OF DEATH Month Day Year <b>January 26th, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 9th, 1871</b>
9 AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours M.n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY <b>USA</b>	
13 FATHER'S NAME <b>Joseph Bruner</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Kirby</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT Address <b>Miss Ella Bruner, 48 Broadway, F'bg. Md.</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic Heart Failure</b> DUE TO <b>Cardiovascular Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15 years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 25, 1958</b> to <b>January 26, 1959</b> that I last saw the deceased alive on <b>1/23, 1959</b> and that death occurred at <b>9:45</b> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Hilda Jane Walters</b> M.D.		ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b> DATE SIGNED <b>1/28/59</b>	
PHYSICIAN'S NAME (Type) <b>Hilda Jane Walters, M. D.</b>			
22a. BURIAL, CREMAT ON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 29 1959</b> 24b REGISTRAR'S SIGNATURE <b>Chas E. Hous</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG238 1-30-59 et

## CERTIFICATE OF DEATH

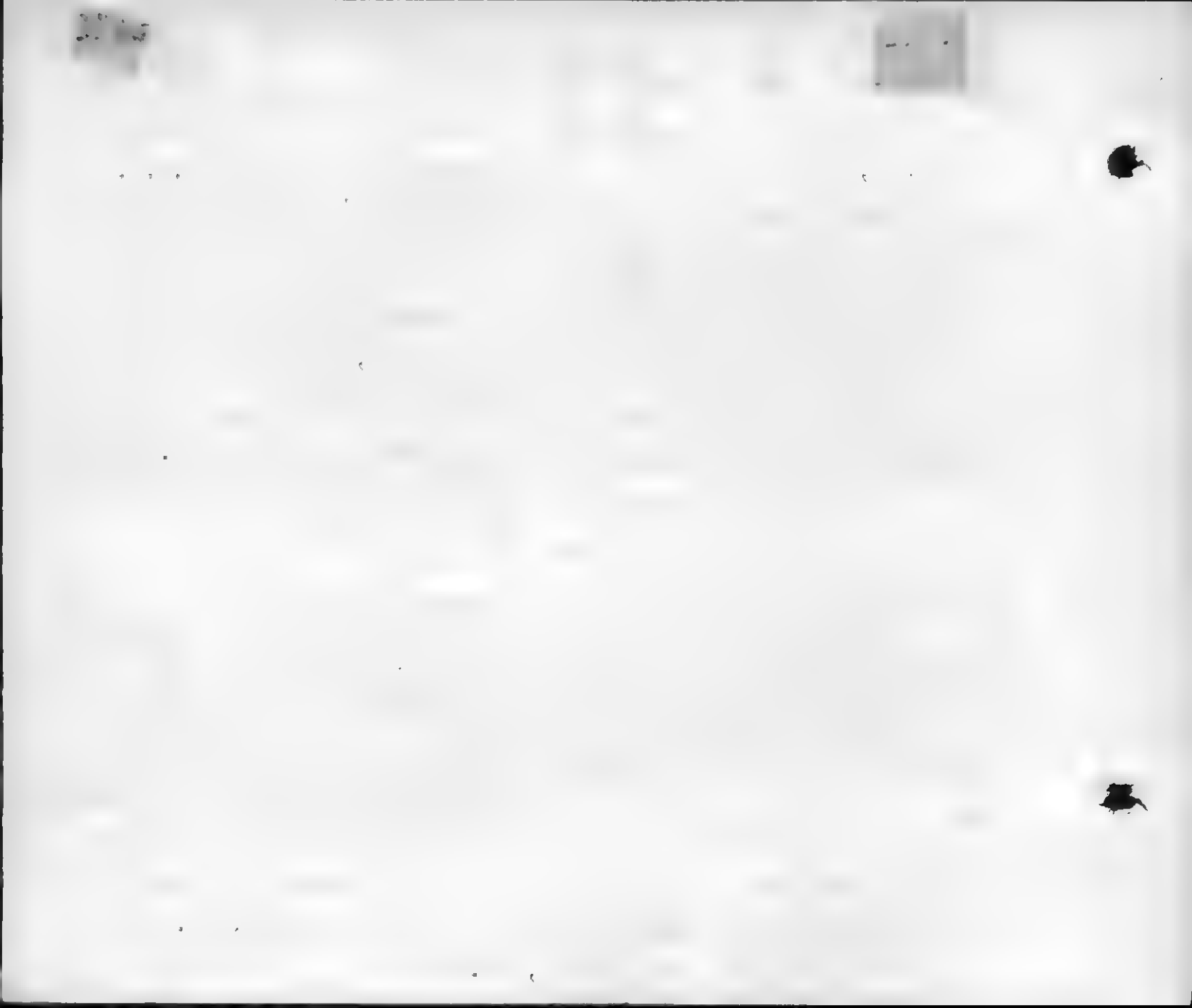
00012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale, MD.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodland, R.F.D.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Braddock Road</b>		d. STREET ADDRESS <b>Rural Route, Frostburg</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANET DUNN BUSKIRK</b>		4. DATE OF DEATH Month Day Year <b>1/21/1959 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>10/23/1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lark Hill, Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Nathaniel Dunn</b>	
14. MOTHER'S MAIDEN NAME <b>Janet Neilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>FRANK BUSKIRK, KLONDYKE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>/</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frostburg, MD.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>1-3-</b> 19 <b>59</b> , to <b>1-21-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>1-16-</b> 19 <b>59</b> , and that death occurred at <b>2:06</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Brings</b>		ADDRESS (Street, city or town, state) <b>516 GREENE ST.</b>	
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS</b>		DATE SIGNED <b>1-23-59</b>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>1/24/1959 Burial</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		24a. REC'D BY REGISTRAR <b>LONACONING, MD.</b>	
24b. REGISTRAR'S SIGNATURE <b>26 59</b>		24c. REGISTRAR'S SIGNATURE <b>Carroll L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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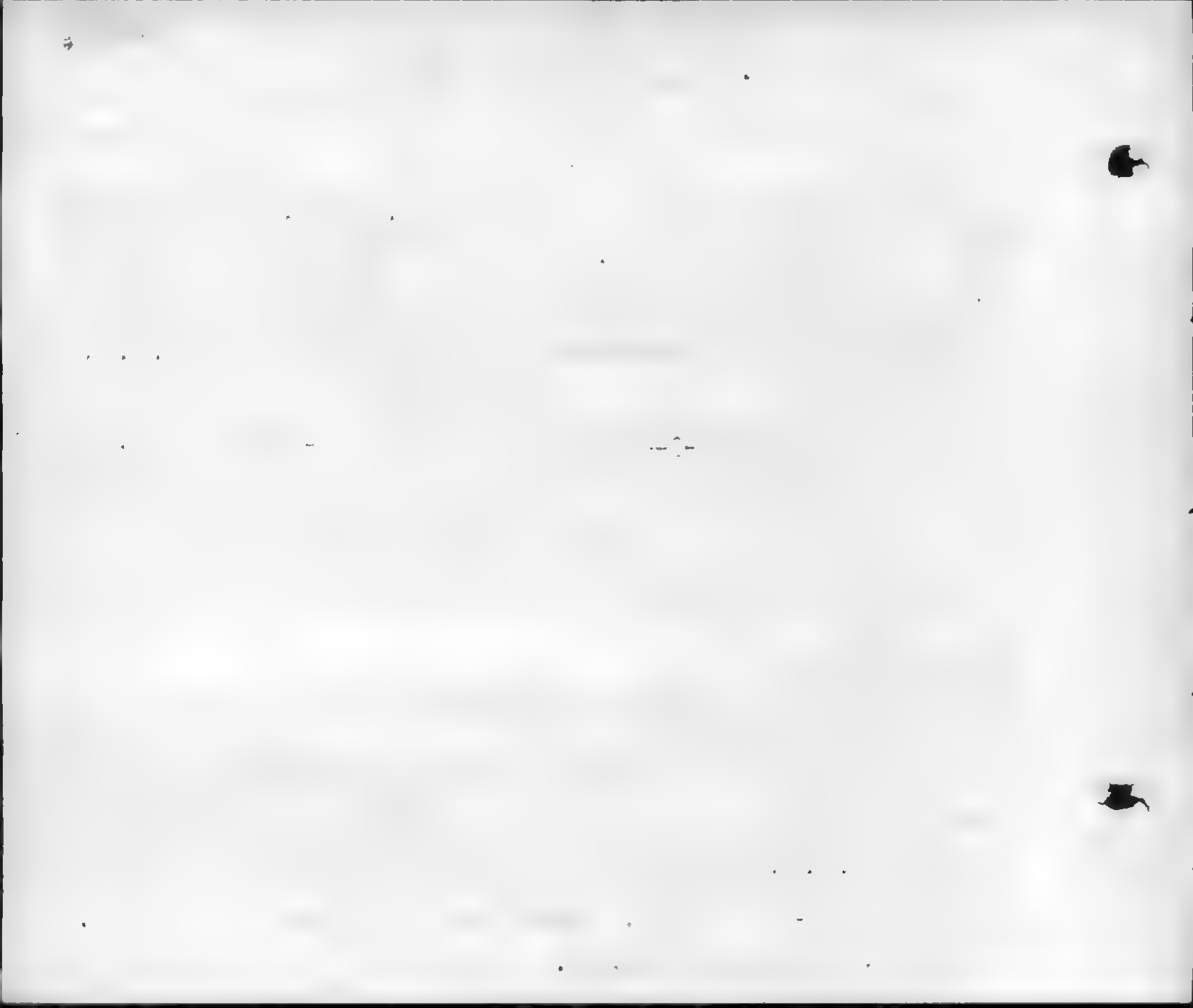
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
f. STREET ADDRESS <b>317 E. MAIN ST.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>E.</b> Last <b>CARPENTER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 27,</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>BENJAMIN HAINES</b>		14. MOTHER'S MAIDEN NAME <b>NANCY ORFETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>217-30-1585</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b> DUE TO <b>Hypertensive and arteriosclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>13 Jan., 1959</b> , to <b>22 Jan., 1959</b> , that I last saw the deceased alive on <b>22 Jan., 1959</b> , and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		ADDRESS (Street, city or town, state) <b>1225 Centre St. Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		DATE SIGNED <b>23 Jan. 59</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

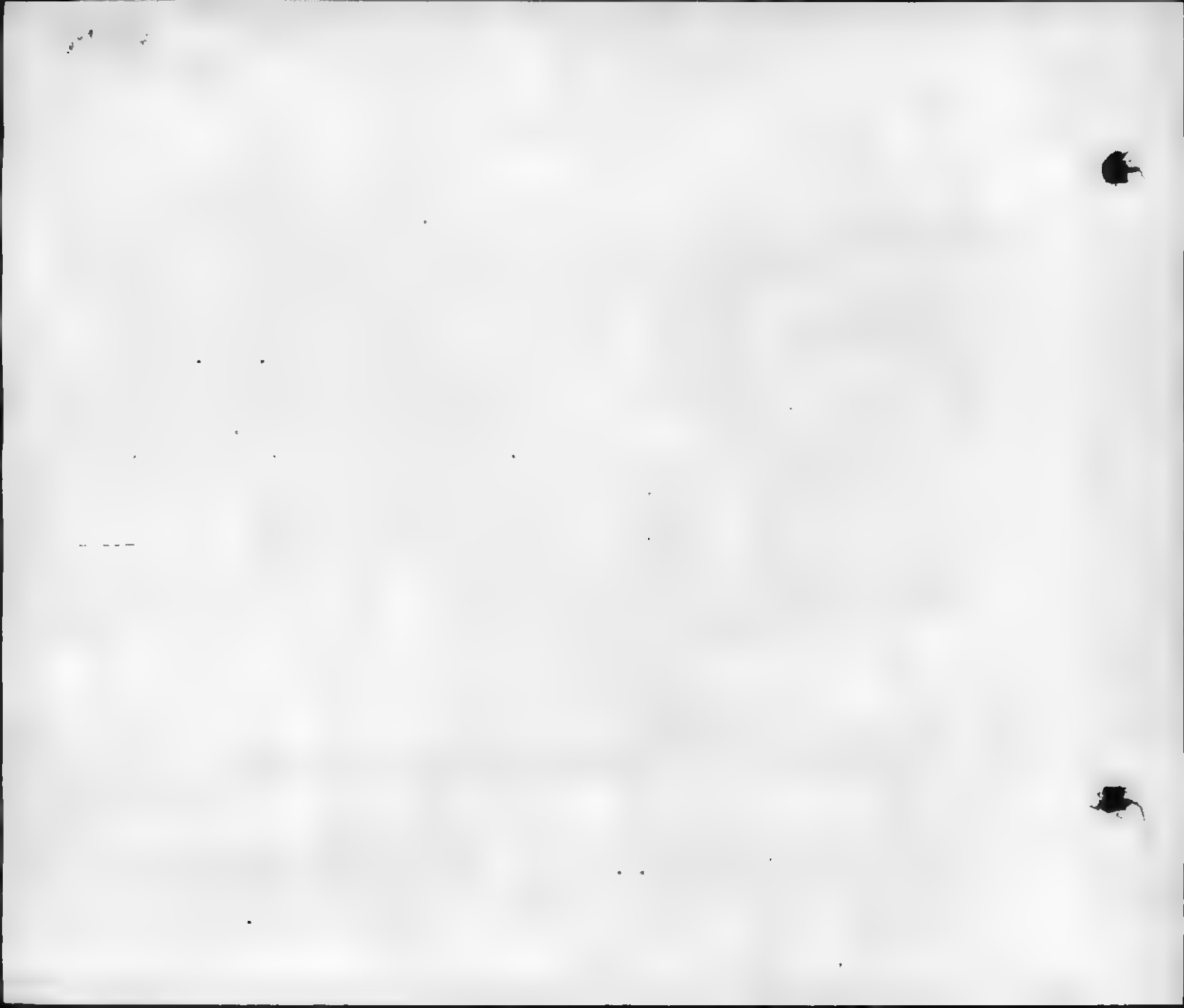
00014

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>D O A</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution-Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>Rt. 1, Valley Road</u>	
3. NAME OF DECEASED (Type or print) <u>William M Cavender</u> First Middle Last 4. DATE OF DEATH <u>January 5, 1959</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 14, 1878</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>80</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (State or foreign country) <u>Purcell, Bedford Co., Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cavender, (Deceased)</u> 15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Amy Smith (Deceased)</u> 16. SOCIAL SECURITY NO. <u>Rt. 1, Valley Road</u> 17. INFORMANT <u>Mrs. Walter Northcraft, Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4. 2.1 DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>January 5, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J/ Hafer, Cumberland, Maryland</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem. Artemas, Pa.</u> 22d. LOCATION (City, town, or county) _____ (State) _____	
24a. REC'D BY REGISTRAR <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>J. L. ...</u>	



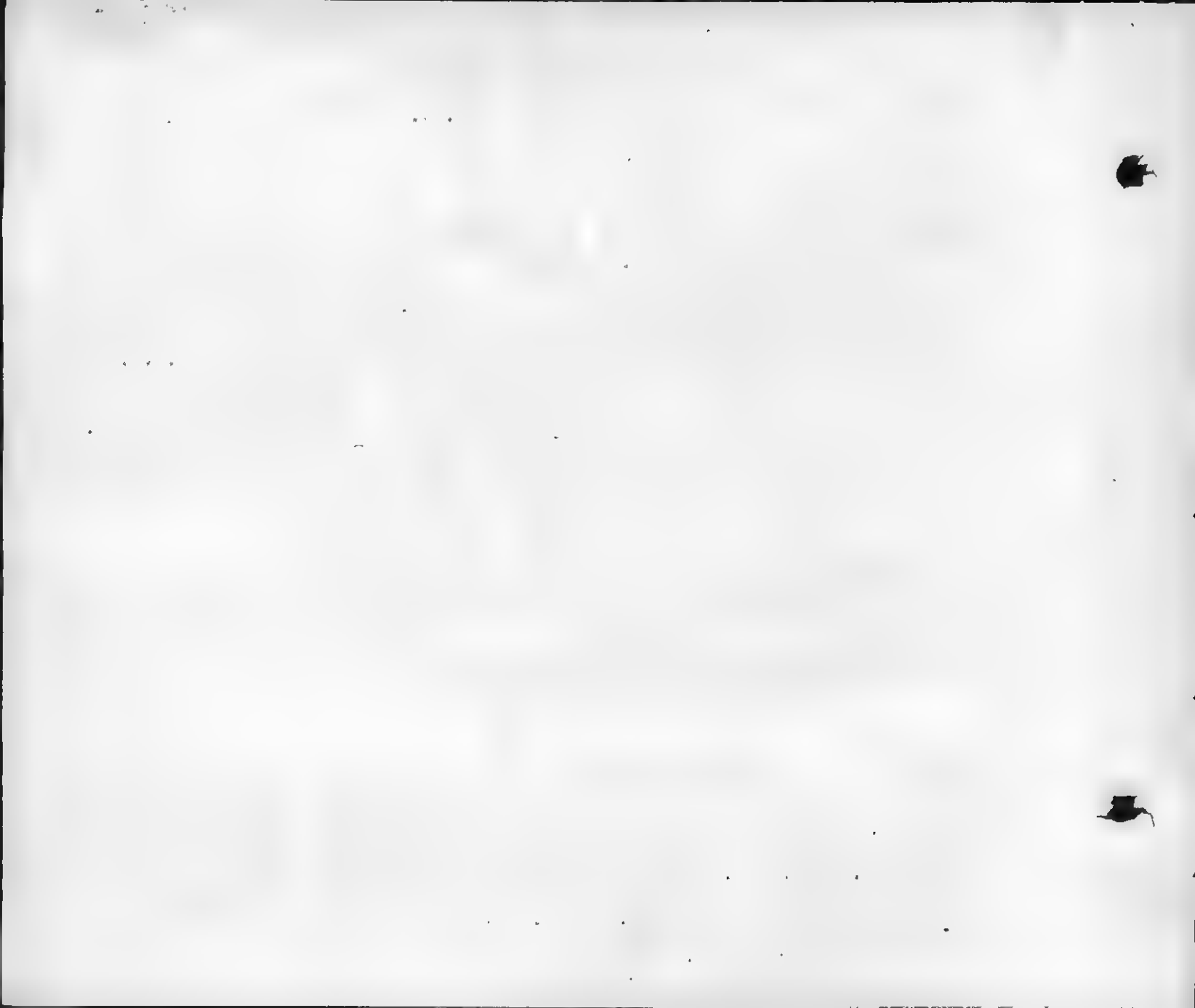


## 9 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>W.VA.</b> b. COUNTY <b>Mineral</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT ASHBY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>B.</b> Last <b>CHANEY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>15</b> Year <b>1959</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 6, 1913</b>		
9. AGE (In years last birthday) yrs <b>45</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVI WILSON</b>				14. MOTHER'S MAIDEN NAME <b>AGNES Winebrenner</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>WARWICK &amp; MEMORIAL AVE. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic Acidosis &amp; coma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>1 wk?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pancreatitis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-14</b> , 19 <b>59</b> , to <b>1-15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-15</b> , 19 <b>59</b> , and that death occurred at <b>5:03 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland</b> DATE SIGNED <b>1-15-59</b>								
ACTUAL SIGNATURE <b>William P. James</b> M.D.				DATE SIGNED <b>1-15-59</b>				
PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>				ADDRESS <b>Cumberland</b>				
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William P. James</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

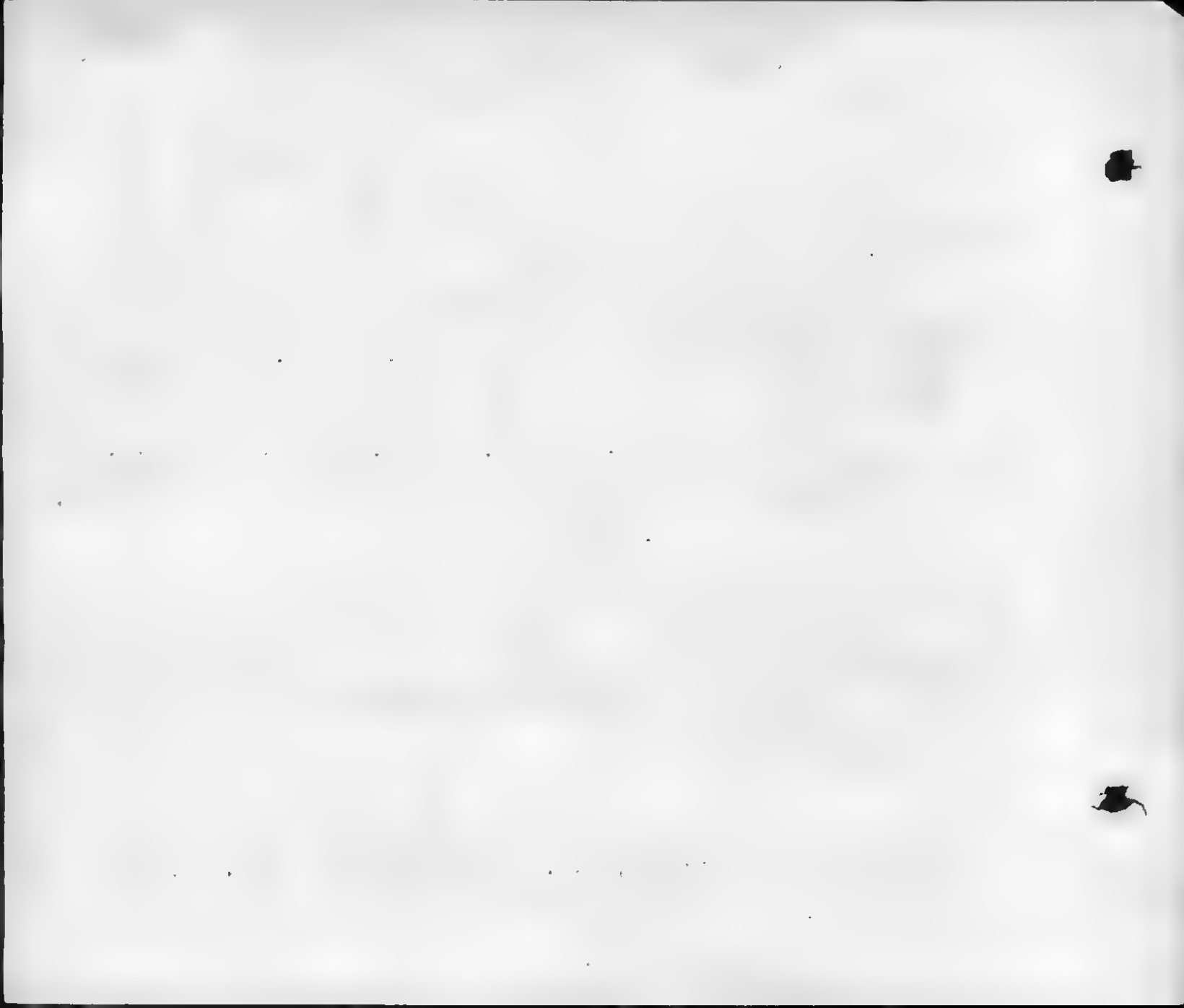
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00016

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegheny</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Pennsylvania</b> COUNTY <b>Bedford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>Ellerslie</b>		c. LENGTH OF STAY IN 1b <b>Londonerry Township</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Hyndman RD#1</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence Wesley Clites</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1904</b>
9. AGE (in years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Carman</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11c. BIRTHPLACE (State or foreign country) <b>Hyndman, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wesley Clites</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Witt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>405-10-7287</b>	
17. INFORMANT <b>Mrs. Annie M. Clites</b>		Address <b>Hyndman, Pa. RD#1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hanging</b> (c) <b>174x</b> DUE TO causing the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Jan. 23, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa. RD#1</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigh</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 27 '59</b>	
ADDRESS <b>Hyndman, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00017

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>		c. LENGTH OF STAY IN 1b <b>X Ellerslie</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellerslie</b> d. STREET ADDRESS		e. IS PERSON ON A FARIAS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First <b>B. Conner</b>		Middle <b>B. Conner</b>		Last <b>B. Conner</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 17, 1892</b>		9. AGE (In years last birthday) <b>66</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ellerslie Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Emmanuel Lowery</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Witt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George Lester Conner, Ellerslie Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Occlusion</b> [a], stating the underlying cause lost. (c) <b>Coronary Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Jan. 10, 1959</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hyndman, Pa. RD #1</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey H. Zeigler</i>		ADDRESS <b>Hyndman, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '59</b>		24b. REGISTRAR'S SIGNATURE <i>James S. Shaul</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 1 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

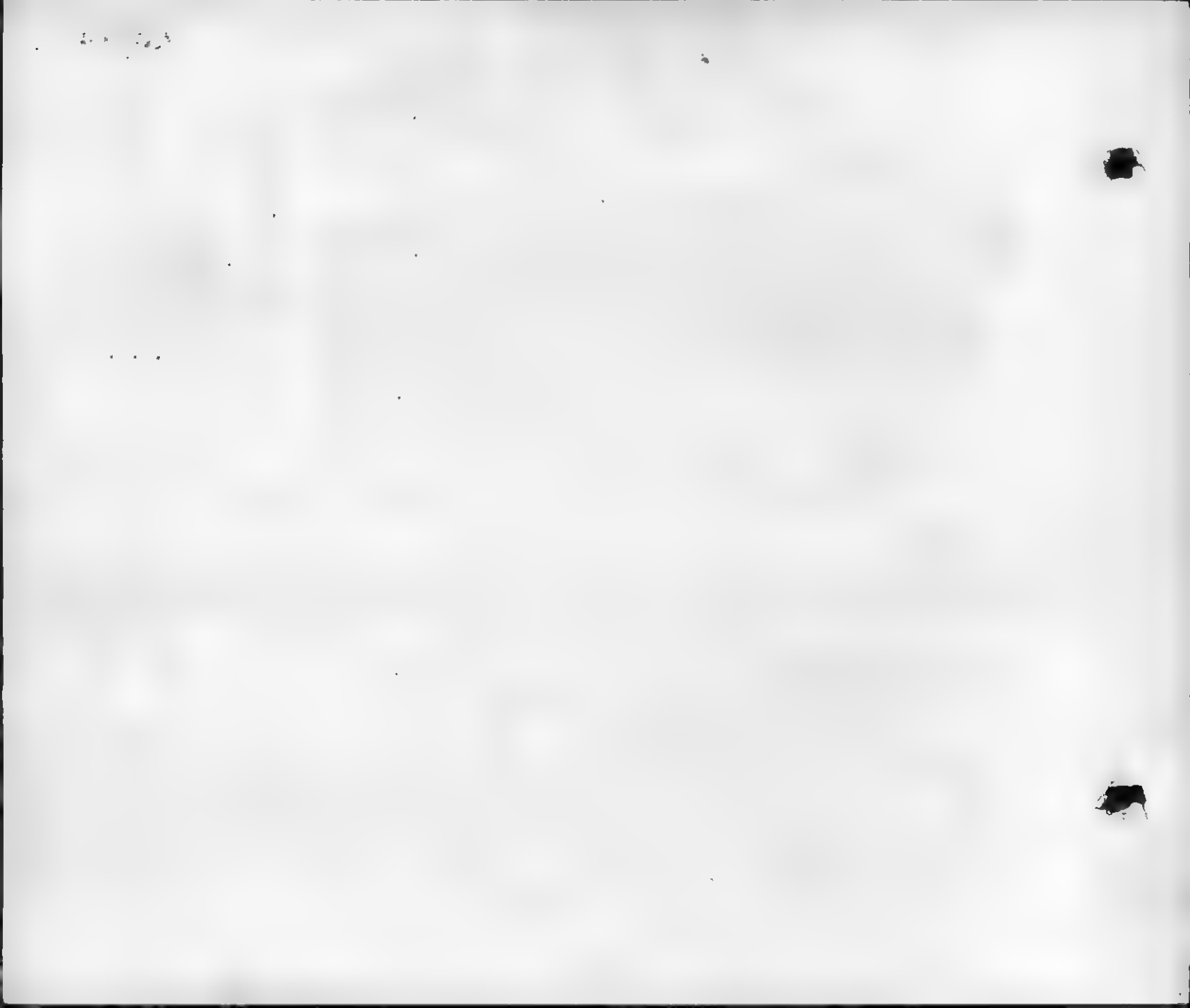
00018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>519 Williams Street</b>	
3. NAME OF DECEASED (Type or print) <b>First Elbert Middle Cosgrove</b>		4. DATE OF DEATH <b>Month Jan. Day 17 Year 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Cosgrove</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Judy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs Helen Cosgrove, Cumberland, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Chronic Myocarditis with Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-14-1959</b> to <b>1-17-1959</b> that I last saw the deceased alive on <b>1-14-1959</b> and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>16 Green Street, Cumberland, Md</b> DATE SIGNED <b>1-18-59</b>	
FOUR SIGNATURE <b>J. T. Johnson Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. T. Johnson Jr., M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Home</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Sten Inc</b> ADDRESS <b>Cumb. Md</b>		24a. REC'D BY REGISTRAR <b>JAN 20 1959</b> 24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12

## CERTIFICATE OF DEATH

Reg. Dist. No.

00020

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>44 MINS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>627 ELWOOD STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL Mary</b> Last <b>COYLE</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 25, 1959</b>		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>	
13. FATHER'S NAME <b>JAMES E. COYLE</b>				14. MOTHER'S MAIDEN NAME <b>MARY M KILDUFF</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hydrops Fetalis</b> <b>770.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premature Separation of Placenta</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 Jan., 1959</b> , to <b>25 Jan., 1959</b> , that I last saw the deceased alive on <b>25 Jan., 1959</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leland Ransom</b>		ADDRESS (Street, city or town, state) <b>63 Green St., Cumberland, Md.</b>		DATE SIGNED <b>26 Jan 59</b>			
PHYSICIAN'S NAME (Type) <b>DR. LELAND RANSOM</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumb. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>		ADDRESS <b>Cumb. Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>L. M. J. Fink</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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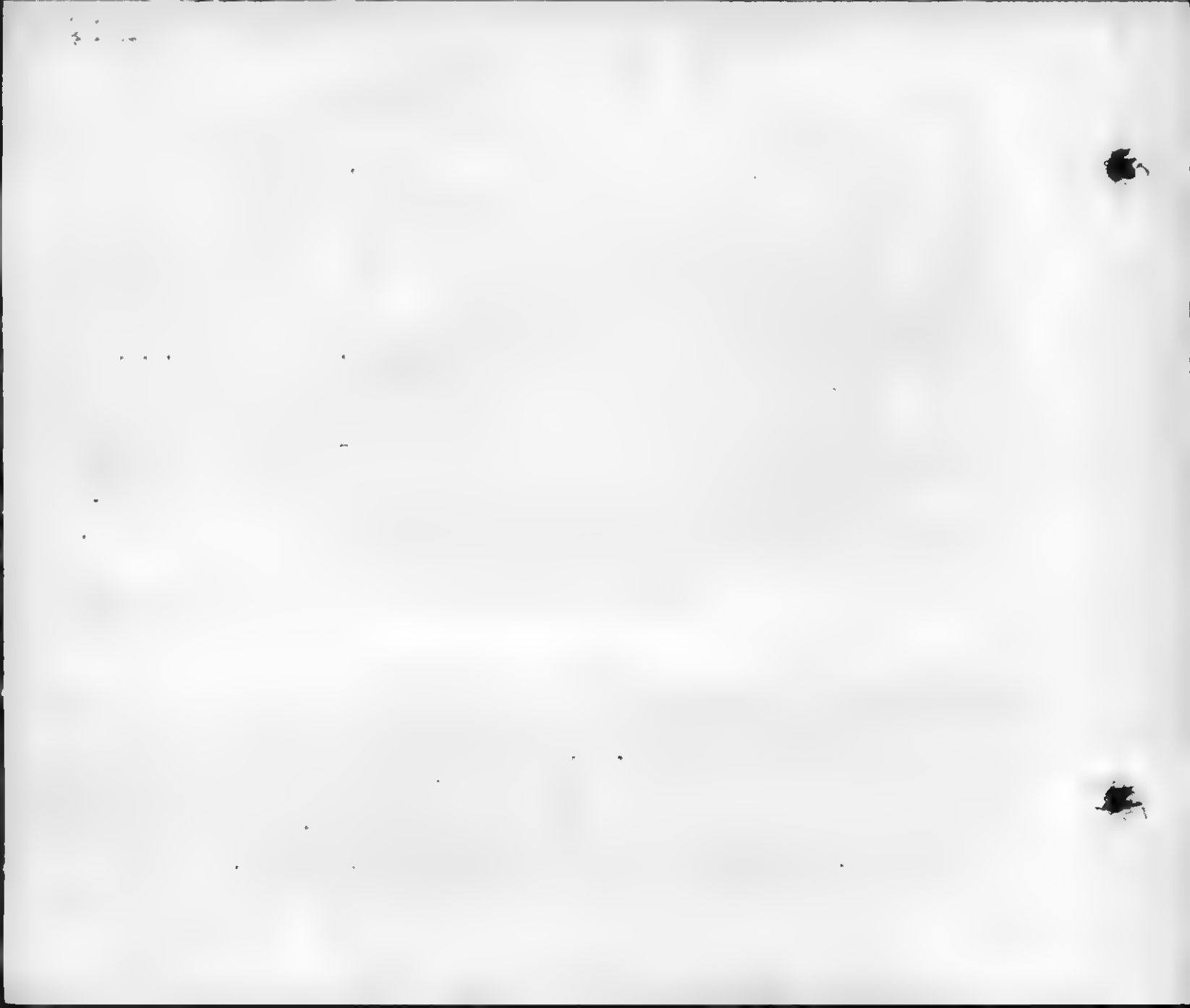


## 13 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>35 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		d. STREET ADDRESS <b>901 GLENMORE STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>CRUTHERS</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 31, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEWART</b>		14. MOTHER'S MAIDEN NAME <b>ANN NORWOOD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>		<b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized visceral failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced age</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 wk.</b> <b>20 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 24, 1958, January 28, 1959</b> , that I last saw the deceased alive on <b>January 28, 1959</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>140 Bedford St. Cumberland, Maryland.</b> DATE SIGNED <b>1/28/59</b>			
ACTUAL SIGNATURE <b>James H. Hallinan MD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PHYSICIAN'S NAME (Type) <b>DR. JAMES HALLINAN</b>		<b>Cumberland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cook's Cem</b>	22d. LOCATION (City, town or county) (State) <b>Vellersburg Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>		ADDRESS <b>Cumb. Md</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Kauer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14 CERTIFICATE OF DEATH

00022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVES.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
f. STREET ADDRESS <b>10 EUCLID PLACE</b>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>E</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 13, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>59</b> Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Company</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM F. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA PROFIT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Coronary Arteriosclerosis</b> (b) <b>Coronary Arteriosclerosis</b> (c) <b>Coronary Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/4/59</b> , 19 <b>59</b> , to <b>1/9/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/7/59</b> , 19 <b>59</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>1/9/59</b>							
ACTUAL SIGNATURE <b>R. J. Williams</b> M.D.				PHYSICIAN'S NAME (Type) <b>R. J. Williams M.D. 122 So. Centre St, Cumberland, Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Mem. park</b>		22d. LOCATION (City town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. S. S. Ward</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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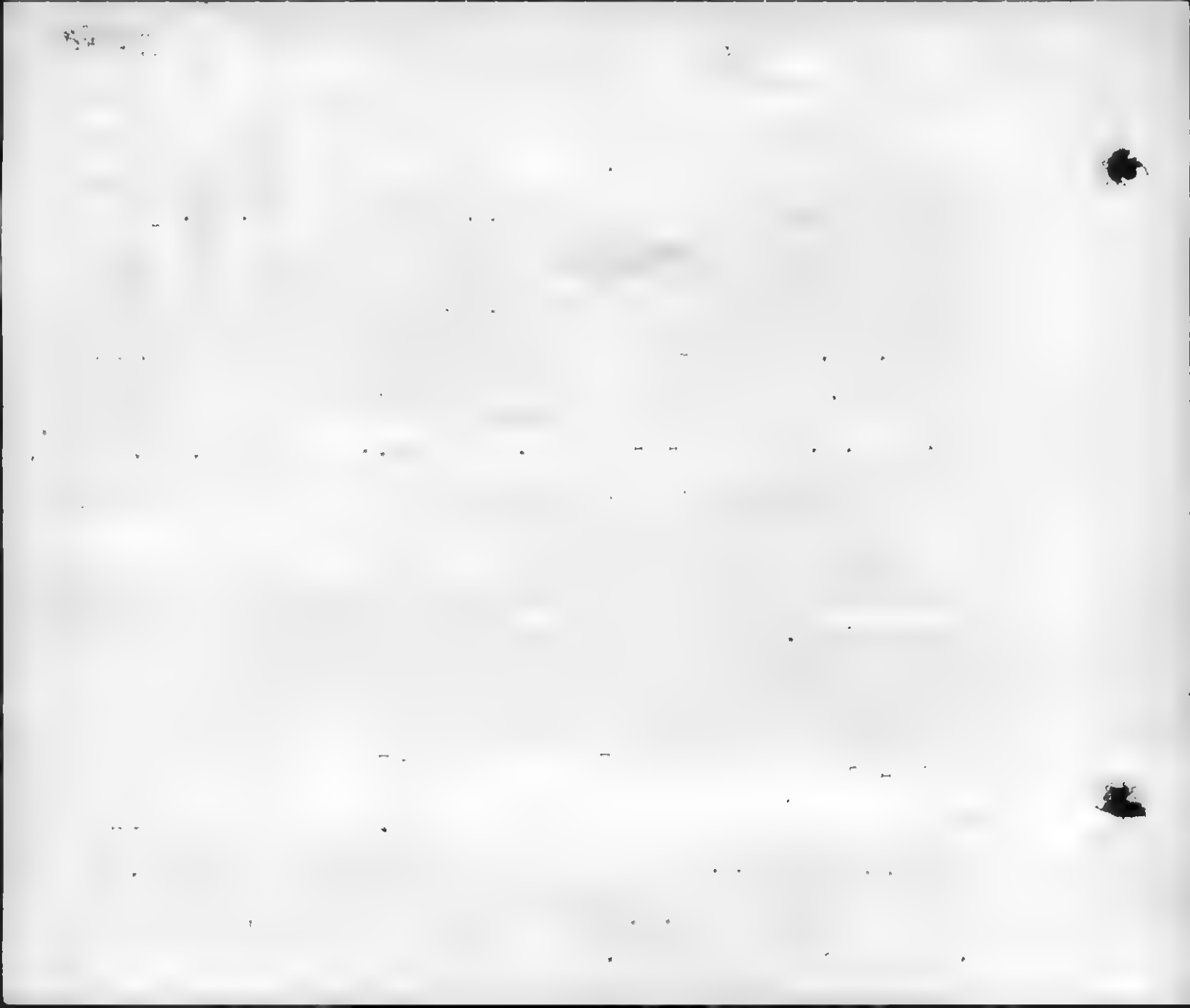
15

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>28 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		/d STREET ADDRESS <b>P.O. Box 143 266 Nat. Hwy.</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Aloysius</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofing Co. Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tri-State Roofing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Davis</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Cordial</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes, W. W. # 1</b>		16. SOCIAL SECURITY NO <b>233-05-3054</b>	
17. INFORMANT <b>Mrs. Margaret M. Davis</b>		Address <b>266 Nat. Hwy. La Vale, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholelithiasis. Chronic duodenal ulcer</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 - 8</b> <b>1953</b> , to <b>1 - 1</b> <b>1959</b> , that I last saw the deceased alive on <b>1 - 1</b> <b>1959</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b> DATE SIGNED <b>1-2-59</b>			
ACTUAL SIGNATURE <b>R. W. Ballin</b>		PHYSICIAN'S NAME (Type) <b>R. W. Ballin, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 6 59</b>		24b. REGISTRAR'S SIGNATURE <b>Walter L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABy</b> Middle <b>GIRL</b> Last <b>DOLLY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 17, 1959</b>
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR IF UNDER 74 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>ROBERT L. DOLLY</b>		14. MOTHER'S MAIDEN NAME <b>ELEANOR M. MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7541</b> DUE TO <b>Chloroform Poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Believed to be a suicide</b> DUE TO <b>(Coronary)</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12:45 PM</b> to <b>1:15 PM</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 Jan</b> , 19 <b>59</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>James B. Whitworth</b> M. D.			
PHYSICIAN'S NAME (Type) <b>DR. W. F. WHITWORTH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Cremation</b>	<b>1-19-59</b>	<b>Memorial Hospital</b>	<b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		DATE <b>JAN 21 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

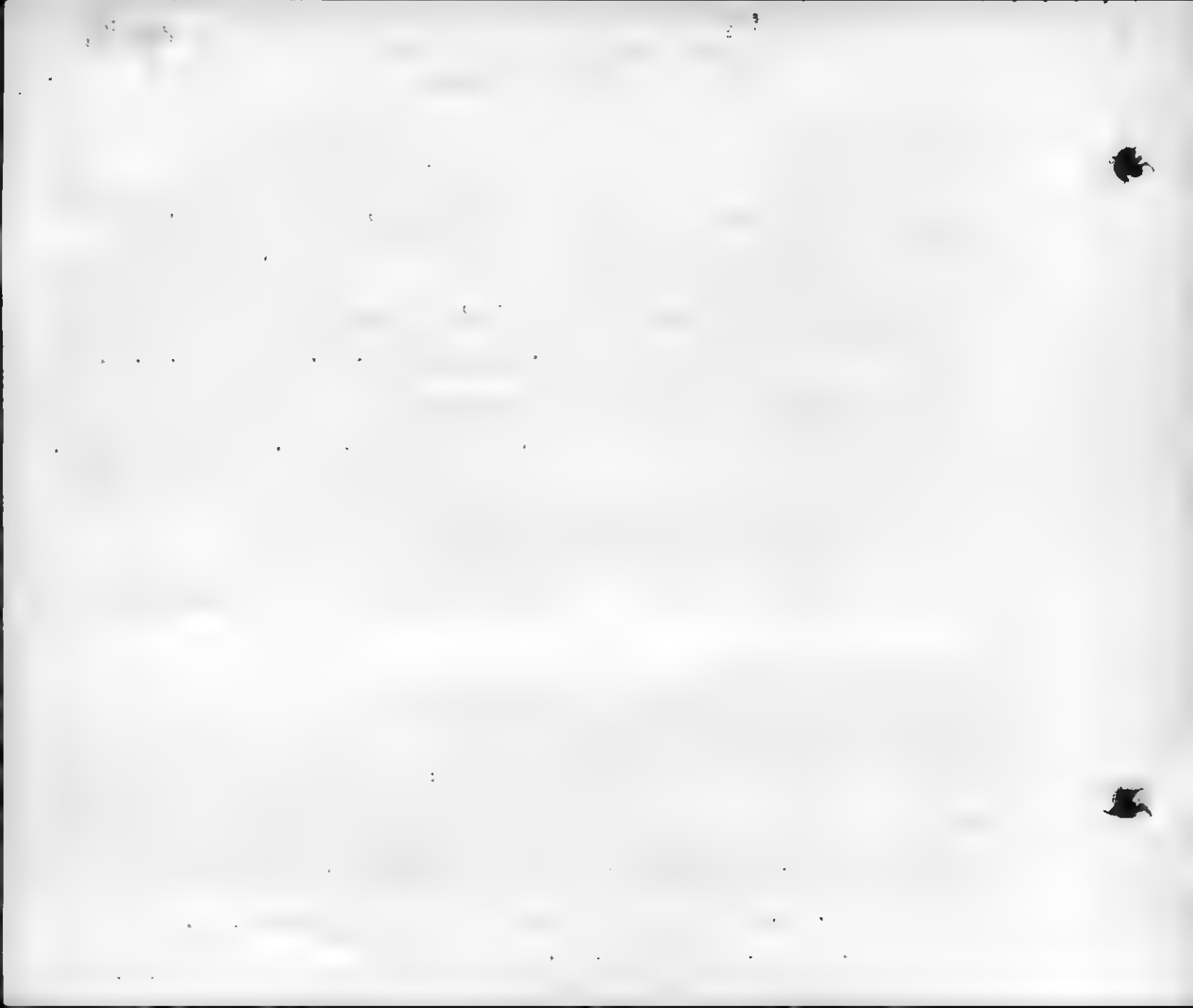
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>Meadow Drive, Cresap Park Rt. 5</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Howard</u> Last <u>Duckworth</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1880</u>		9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Road Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Bloomington, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nelson Duckworth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Yonker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Frank Duckworth Rt. 5 Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 8, 1959</u> to <u>January 15, 1959</u> that I last saw the deceased alive on <u>January 15, 1959</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> DATE SIGNED <u>1/16/59</u>							
ACTUAL SIGNATURE <u>Samuel M. Jacobson, M.D.</u>		Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Chas L. George</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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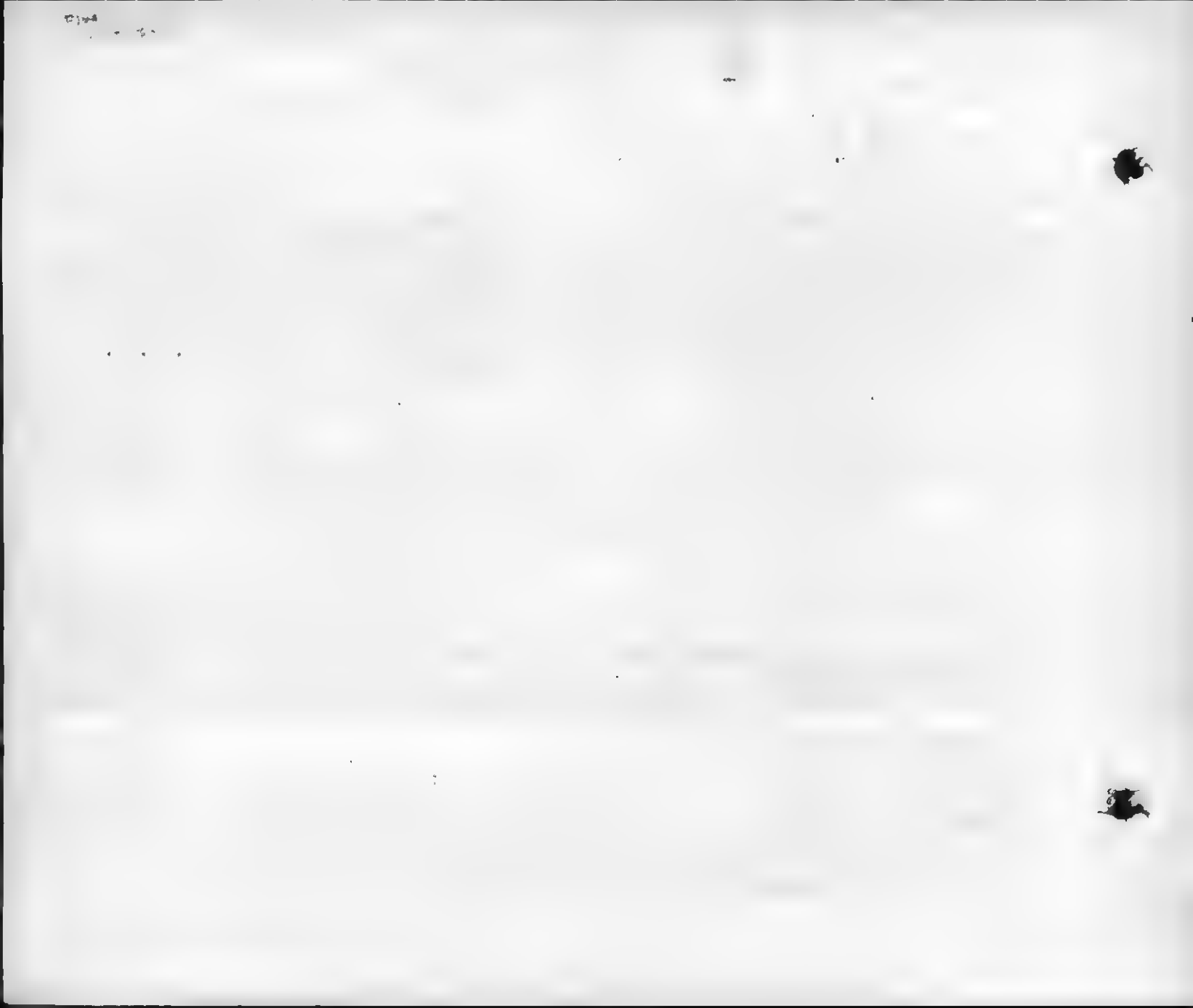
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admittance) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVENUES</b>				d. STREET ADDRESS <b>122 SOUTH LIBERTY STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>E</b> Last <b>EARSON</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 15, 1891</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>LOUIS BORCHERT</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE DRYER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-28-2425</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Infarction</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b> <b>5</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1/16/59</b> , 19 <b>59</b> , to <b>1/17/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/17/59</b> , 19 <b>59</b> , and that death occurred at <b>4:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. J. McChesney</b>				ADDRESS (Street, city or town, state) <b>Cumberland Md</b>			
DATE <b>1/20/59</b>				DATE/SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>1/22/59</b>		<b>Rose Hill Cem</b>		<b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>				ADDRESS <b>Cumbl Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>C. J. Up 9 4 10 22</b>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

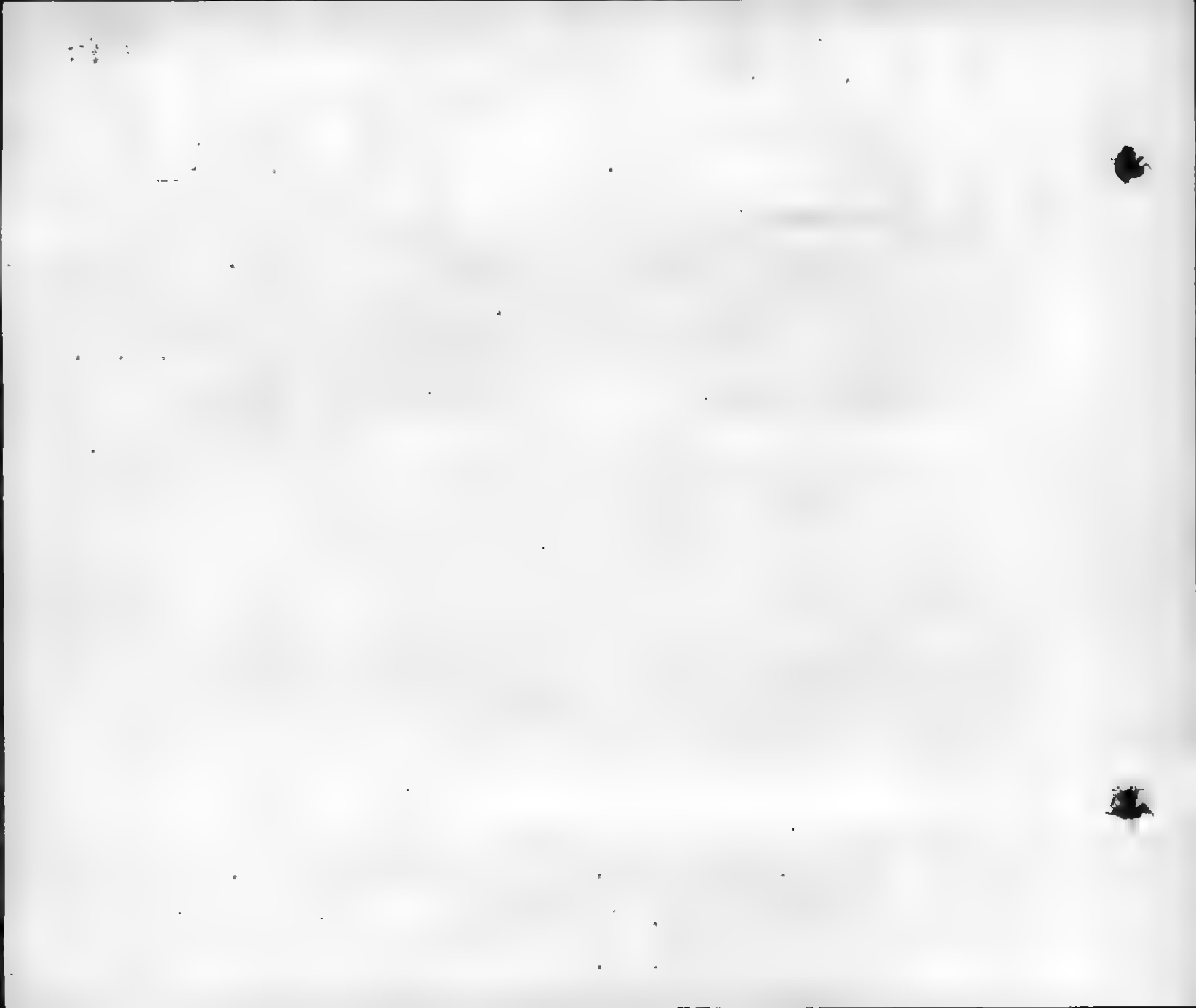
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>7 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. STREET ADDRESS <b>Hope Road</b>	
3. NAME OF DECEASED (Type or print) <b>Marcus Ambrose Fazenbaker</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>22,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Manuel Fazenbaker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Broadwater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Florence Fazenbaker, Frostburg, Rt. 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure - Rt. Side</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>18-27 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 59</b> to <b>Jan. 22, 19 59</b> that I last saw the deceased alive on <b>Jan. 22, 19 59</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Broadway</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>John B. Davis</b> , M.D. PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b> <b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-25-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>John L. Hines</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 4 Cumberland</b>		c. LENGTH OF STAY IN It <b>Rt. # 4 Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mexico Farms</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Delvin</b> Middle <b>C.</b> Last <b>Gainer</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>12,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	IF UNDER 24 HRS Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>	11. BIRTHPLACE (State or foreign country) <b>Phillippi, W. Va.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>George Gainer</b>	
14. MOTHER'S MAIDEN NAME <b>Arminta Ryan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>	
16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Lena Gainer Rt. #4 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b> DUE TO <b>Bronchiogenic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>109</b> (c) <b>109</b>		INTERVAL BETWEEN ONSET AND DEATH <b>109</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1958</b> to <b>Jan 59</b> , that I last saw the deceased alive on <b>Jan 10, 19 59</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Virginia Ave</b> DATE SIGNED <b>1/12/59</b> ACTUAL SIGNATURE <b>G. Overton Himmelwright, M.D.</b> PHYSICIAN'S NAME (Type) <b>G. Overton Himmelwright, MD. Cumberland, Md</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Burial Park</b>	22d. LOCATION (City town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

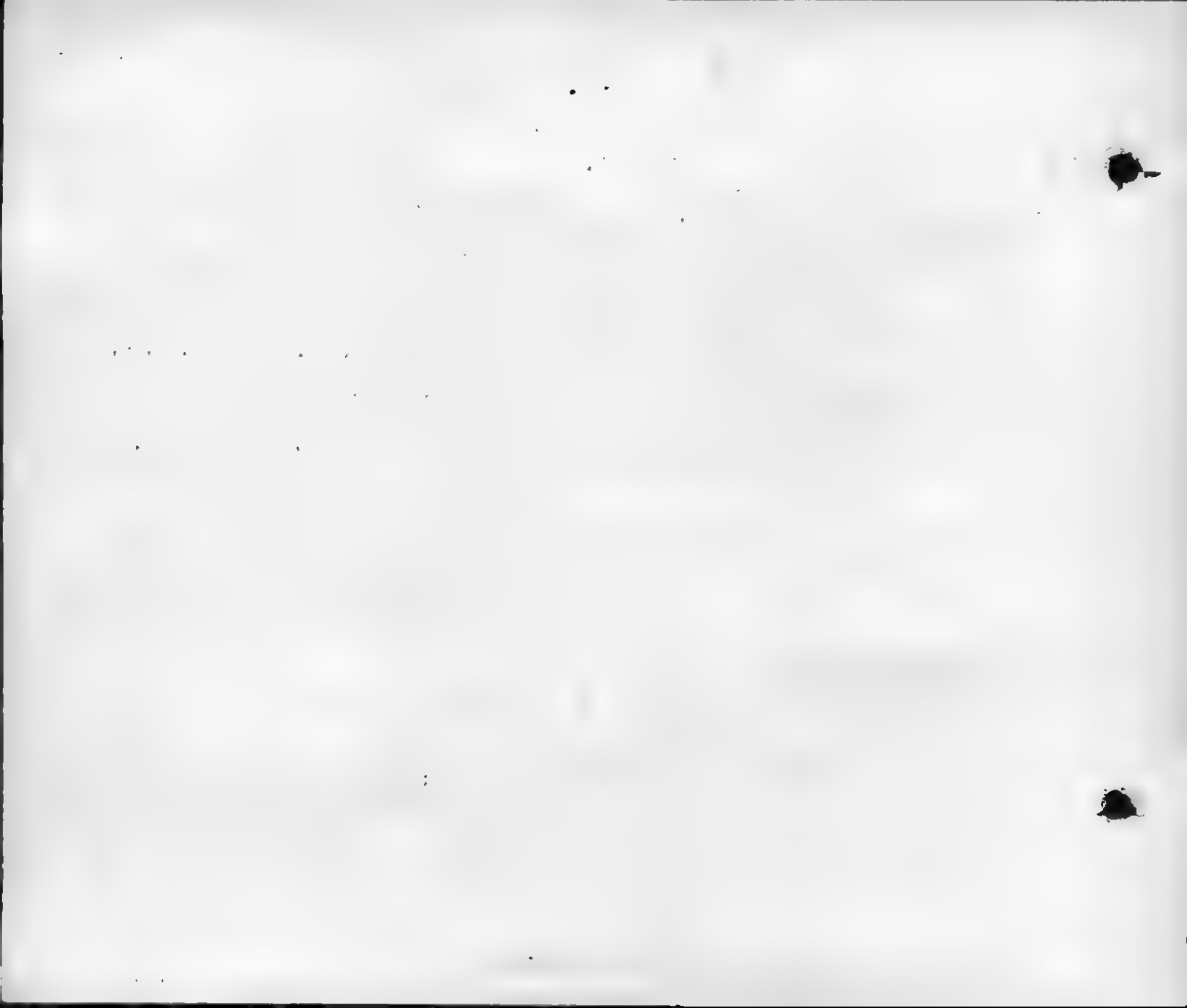
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19

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN TB <b>30 MINS.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>762 FAYETTE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BABY BOY</b>		First <b>BABY BOY</b>		Middle <b>GARLITZ</b>		Last <b>GARLITZ</b>		4. DATE OF DEATH Month <b>JANUARY</b>		Day <b>29</b>		Year <b>19 59</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 29, 1959</b>		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours <b>30</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>VINCENT LEROY GARLITZ</b>								14. MOTHER'S MAIDEN NAME <b>NANCY B HOLLAND</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>omphalocela</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 29, 1959</b> to <b>Jan 29, 1959</b> , that I last saw the deceased alive on <b>Jan 29, 1959</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <b>W.R. Hodges</b>				ADDRESS (Street, city or town, state) <b>1225 Centre St. Cumberland, Md.</b>				DATE SIGNED <b>1/31/59</b>											
PHYSICIAN'S NAME (Type) <b>Dr. L.L. Meuld</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>1/31/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hosp</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital, Cumberland, Md.</b>								ADDRESS				24a. REC'D BY REGISTRAR <b>FEB 1 1959</b>				24b. REGISTRAR'S SIGNATURE <b>William S. Knaus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 20

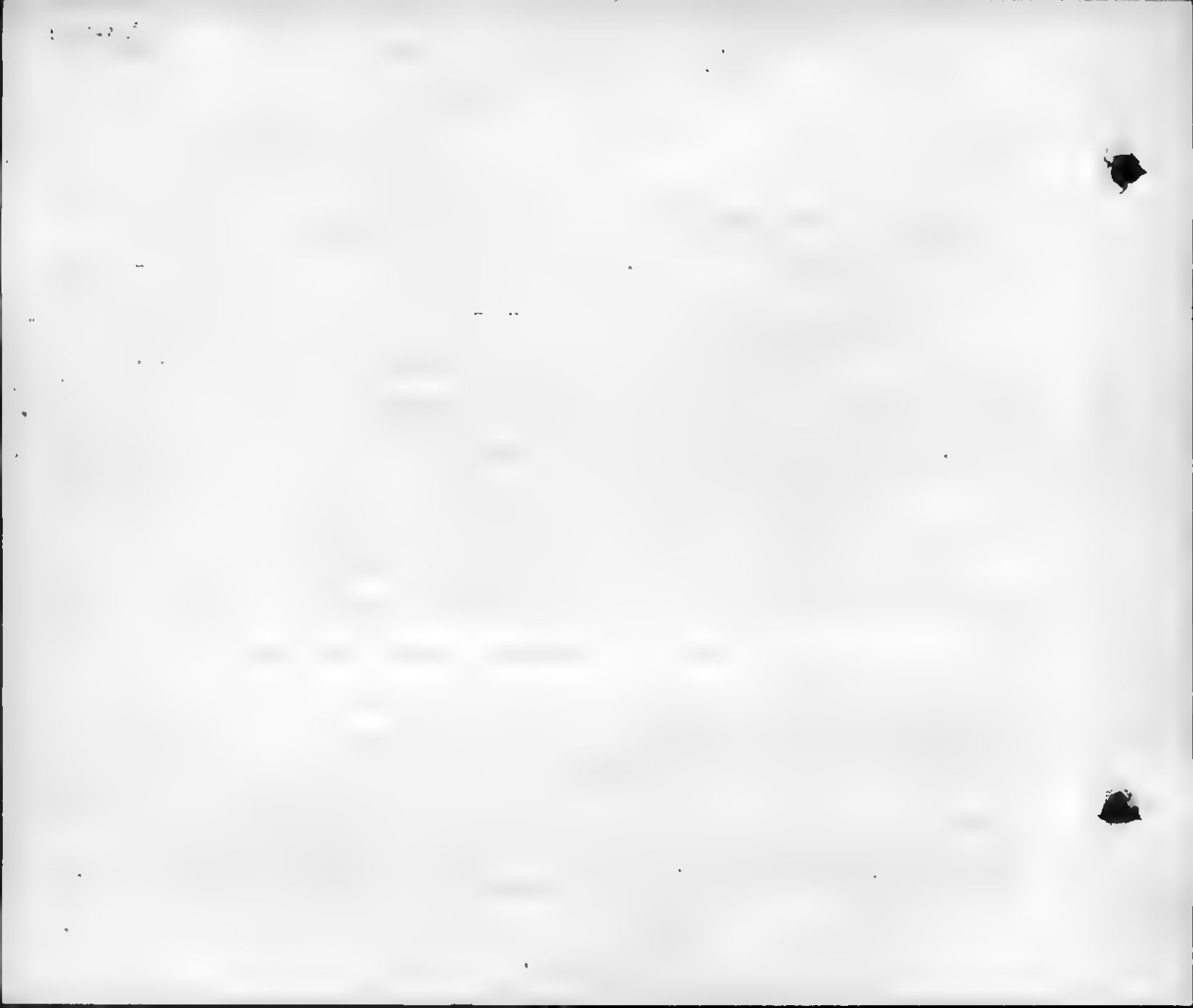
## CERTIFICATE OF DEATH

### 00029

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>two days</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>Decatur Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gregory A. Godlove</u>		4. DATE OF DEATH Month Day Year <u>1-23-1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-56</u>
9. AGE (In years last birthday) <u>Two</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ivan Godlove</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wampler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO <u>Chart</u>	
17. INFORMANT <u>Chart</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>mediastinal pneumothorax</u> <u>570X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spastic bronchitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>59</u> , to <u>1/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Elizabeth Brings</u>		<u>55 Greene Street, Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-25-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vale Summit Methodist</u>	22d. LOCATION (City town, or county) (State) <u>Vale Summit Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. H. Matheny</u>		24a. REC'D BY REGISTRAR <u>Frostburg, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>James P. Hahn</u>		DATE <u>JAN 29 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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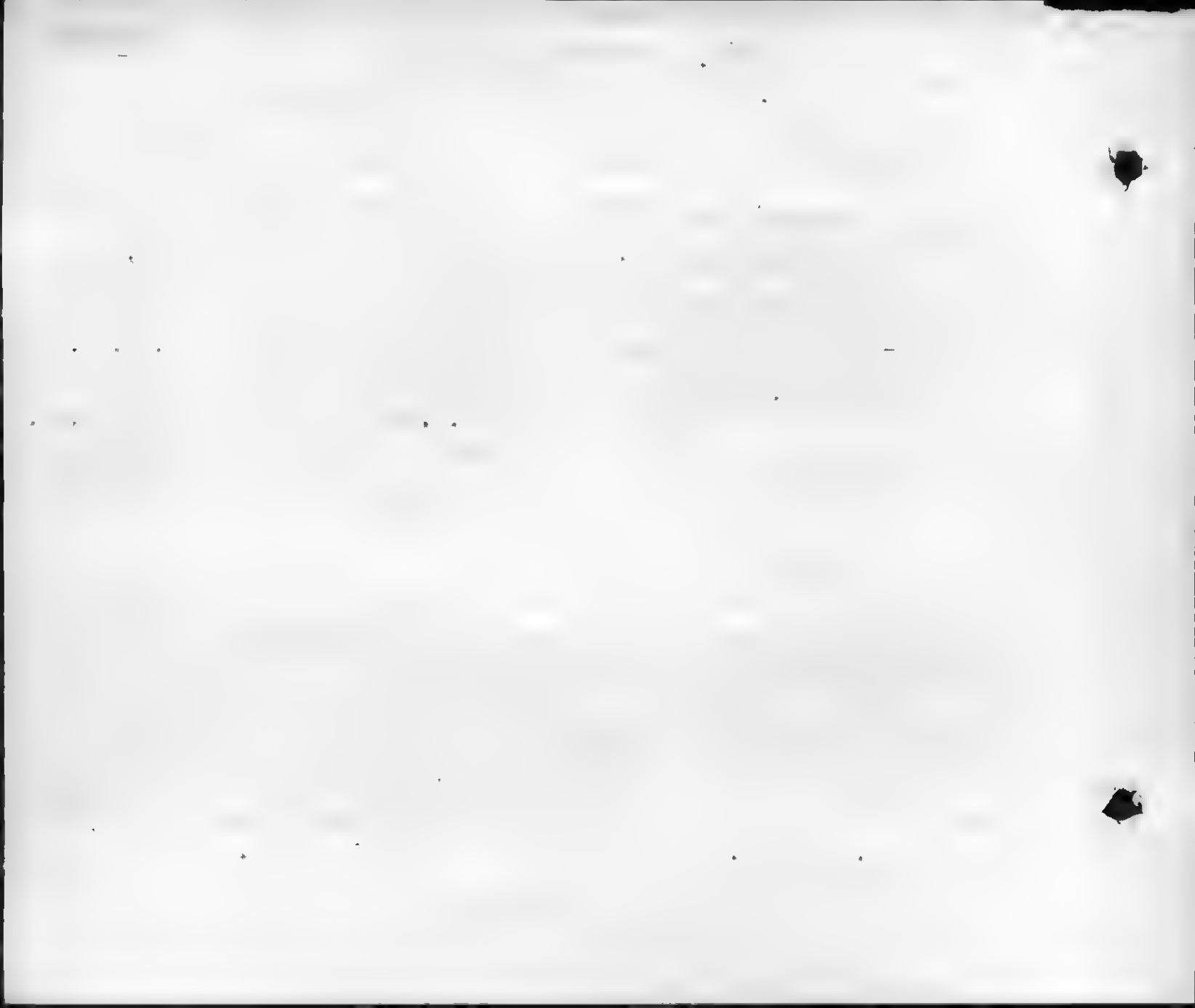
## CERTIFICATE OF DEATH

00030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/19/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
		d. STREET ADDRESS <b>928 Kent Avenue</b>	
		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>R.</b> Last <b>Gowland</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> , Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/1884</b>
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - B &amp; O</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>County Durham, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Railroad Alfred H. Gowland</b>		14. MOTHER'S MAIDEN NAME <b>Esther Heatherington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>P.O.Box 599</b>	
17. INFORMANT <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Ischemia</b>			
422.2 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b>			
DUE TO (c) <b>Chronic Prostatitis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/19/58</b> , 19____, to <b>1/11/59</b> , 19____, that I last saw the deceased alive on <b>1/10/59</b> , 19____, and that death occurred at <b>2:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene Street</b> DATE SIGNED <b>1/12/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>I-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 14 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hester</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00031

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GREEN</b> Last <b>GREEN</b>		4. DATE OF DEATH Month <b>Jan</b> , Day <b>28th</b> , Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan, 28th. 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frostburg</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vincent Green</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Blubaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Vincent Green, Gilmore R.D.D. # 1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 28, 1959</b> , to <b>Jan 28, 1959</b> , that I last saw the deceased alive on <b>Jan 28, 1959</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main ST Lonaconing md</b> DATE SIGNED <b>1.29.59</b> ACTUAL SIGNATURE <b>Leslie R. Miles</b> M.D. PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 30 1959</b>	
24b. REGISTRAR'S SIGNATURE			



# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

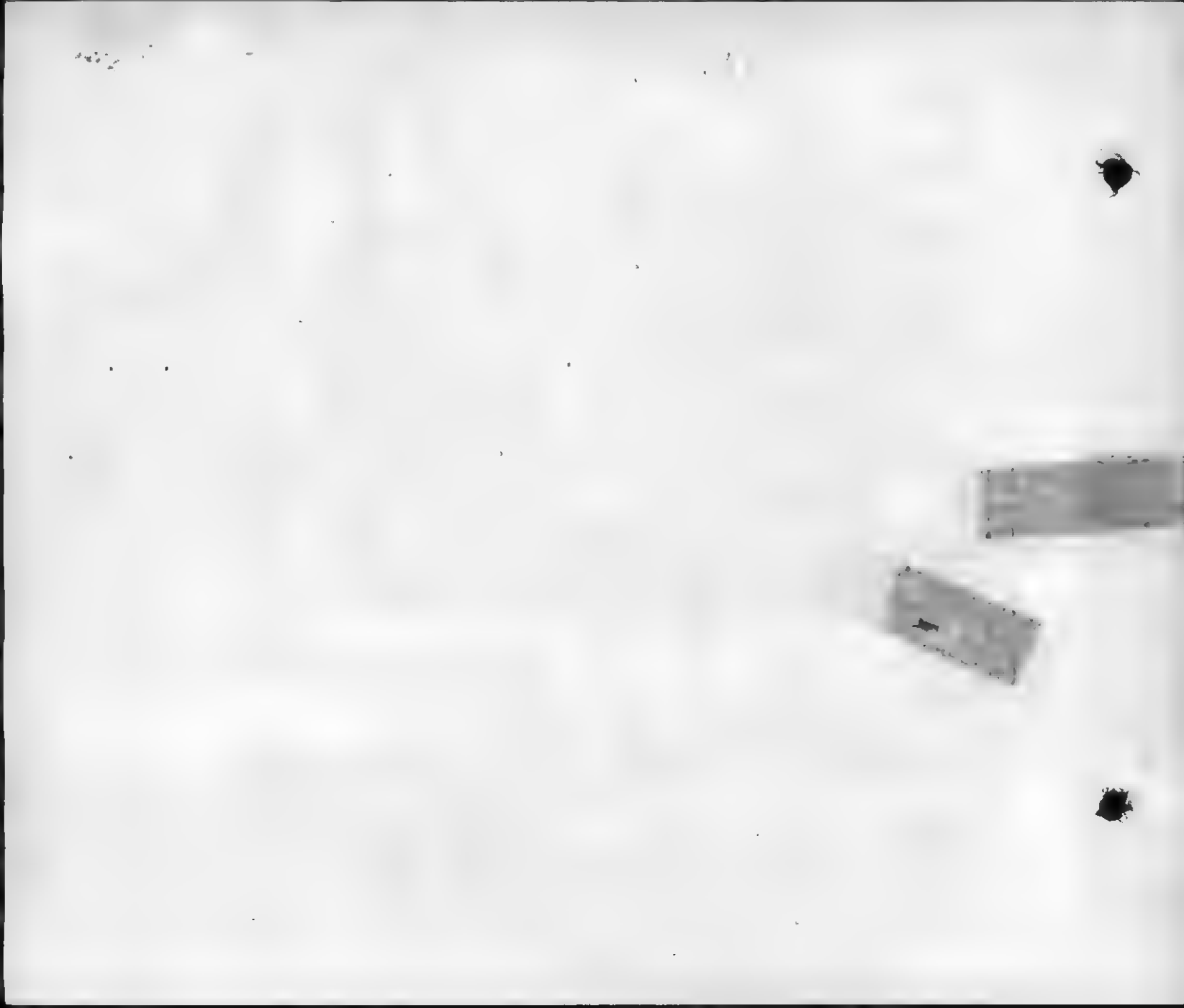
00032

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		d. STREET ADDRESS <b>106 MAIN ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) <b>PATRICK H. GRIFFIN</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>68</b> yrs.	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HR Hours Min.		12. IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR CO.</b>		11. BIRTHPLACE (State or foreign country) <b>WESTERNPORT, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN GRIFFIN</b>			
14. MOTHER'S MAIDEN NAME <b>SARA LANNON</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>CUMBERLAND MD.</b> <b>MRS. MARY WINIFRED STEINER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>67110</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>67110</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. H. FREDLOCK, JR</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>Jan 3 1959</b>			
EXAMINER'S NAME (Type) <b>W. H. FREDLOCK, JR</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>JAN. 5/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>ST. PETERS CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>WESTERNPORT, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. FREDLOCK, JR</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 5 '59</b>			
ADDRESS <b>PIEDMONT, W. VA</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. FREDLOCK, JR</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed by the Deputy Medical Examiner, writing the word "pending" in pencil in the space provided for the signature of the Deputy Medical Examiner. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit receipt. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and at any event within 72 hours after death.



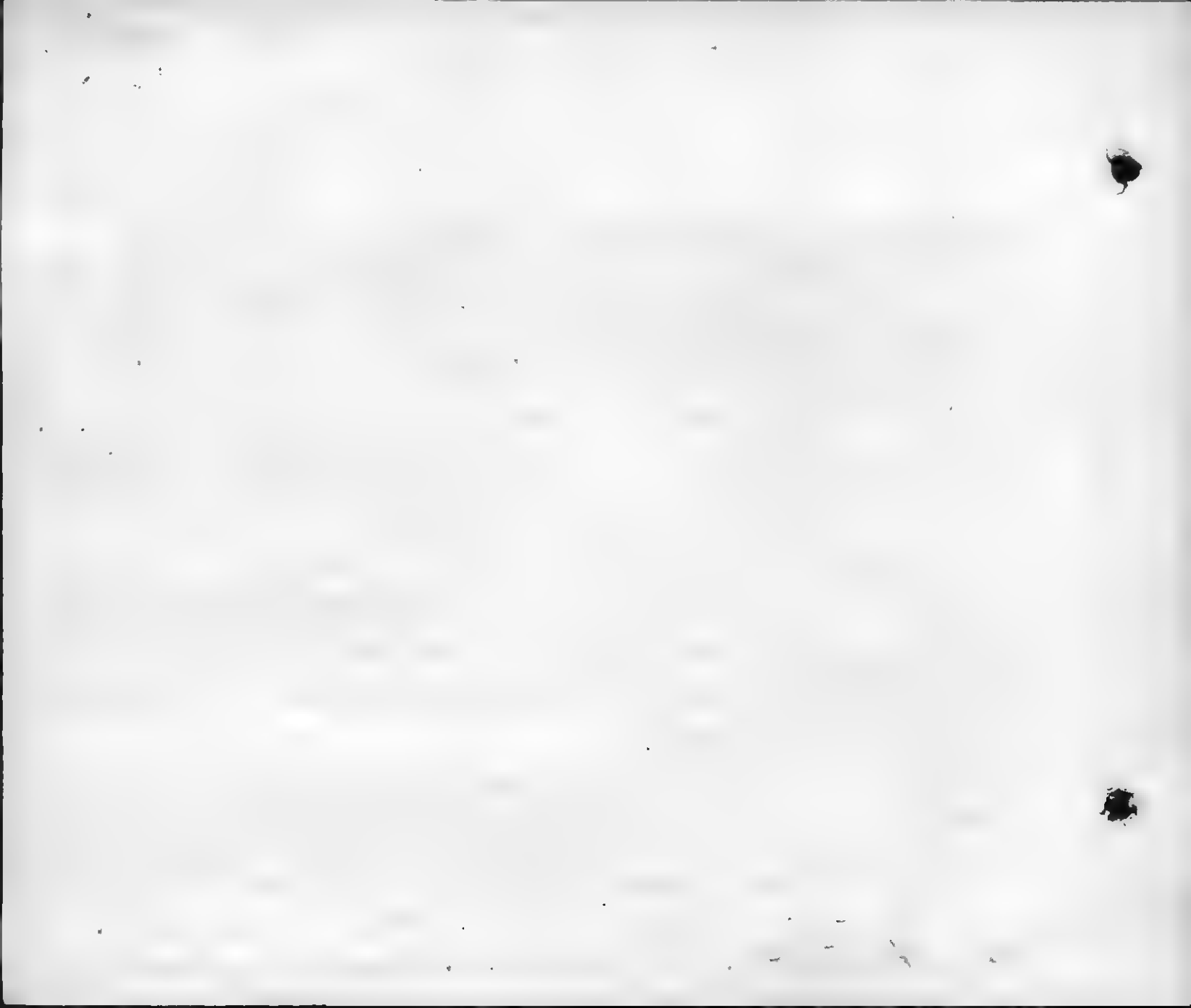
## 72 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
		f. STREET ADDRESS <b>14 West Main</b>	
3 NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>PIERCE</b> Last <b>GRIFFITH</b>		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-1886</b>
9 AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>3</b> Hours <b>59</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Textile Worker Berkowitz Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>A. Beryl Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Rae</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lloyd G. Griffith, 13 Bealls Lane,</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C-V disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>10 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cholecystitis</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/2</b> 19 <b>59</b> , to <b>1/3</b> 19 <b>59</b> , that I last saw the deceased alive on <b>1/3</b> 19 <b>59</b> , and that death occurred at <b>8:15</b> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <b>H. C. Diehl</b>		ADDRESS (Street, city or town, state) <b>39 W. Main St. Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M.D.</b>		DATE SIGNED <b>1/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-5-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harfer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>W. S. S. S.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

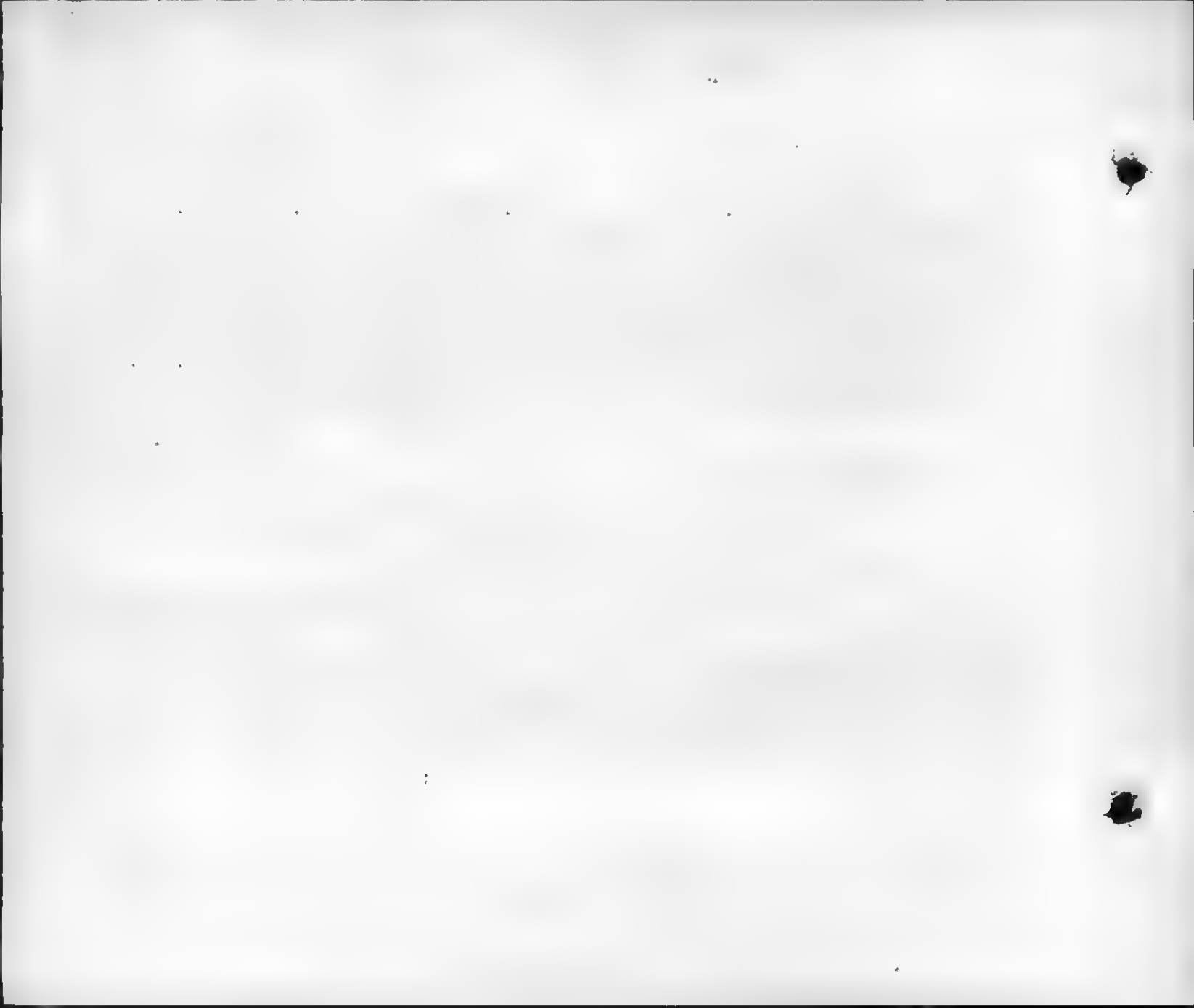
22

## CERTIFICATE OF DEATH

00034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>WARWICK AND MEMORIAL AVE.</b>		d. STREET ADDRESS <b>RT. #1, BREEN POINT, MT. SAVAGE RD.</b>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN</b> First Middle Last <b>M HAINES</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 13, 1870</b>
9. AGE (In years 100 90 80 70 60 50 40 30 20 10 0 yrs)		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE MARVIN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ANN WILLISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Recent Myocardial Infarction</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> to <b>6 Jan 1959</b> , that I last saw the deceased alive on <b>6 Jan 1959</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>59 Green St Cumberland Md</b> DATE SIGNED <b>7 Jan 1959</b>			
ACTUAL SIGNATURE <b>S G WEISMAN</b> M.D.		PHYSICIAN'S NAME (Type) <b>S G WEISMAN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/9/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Hanna</b>	



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## CERTIFICATE OF DEATH

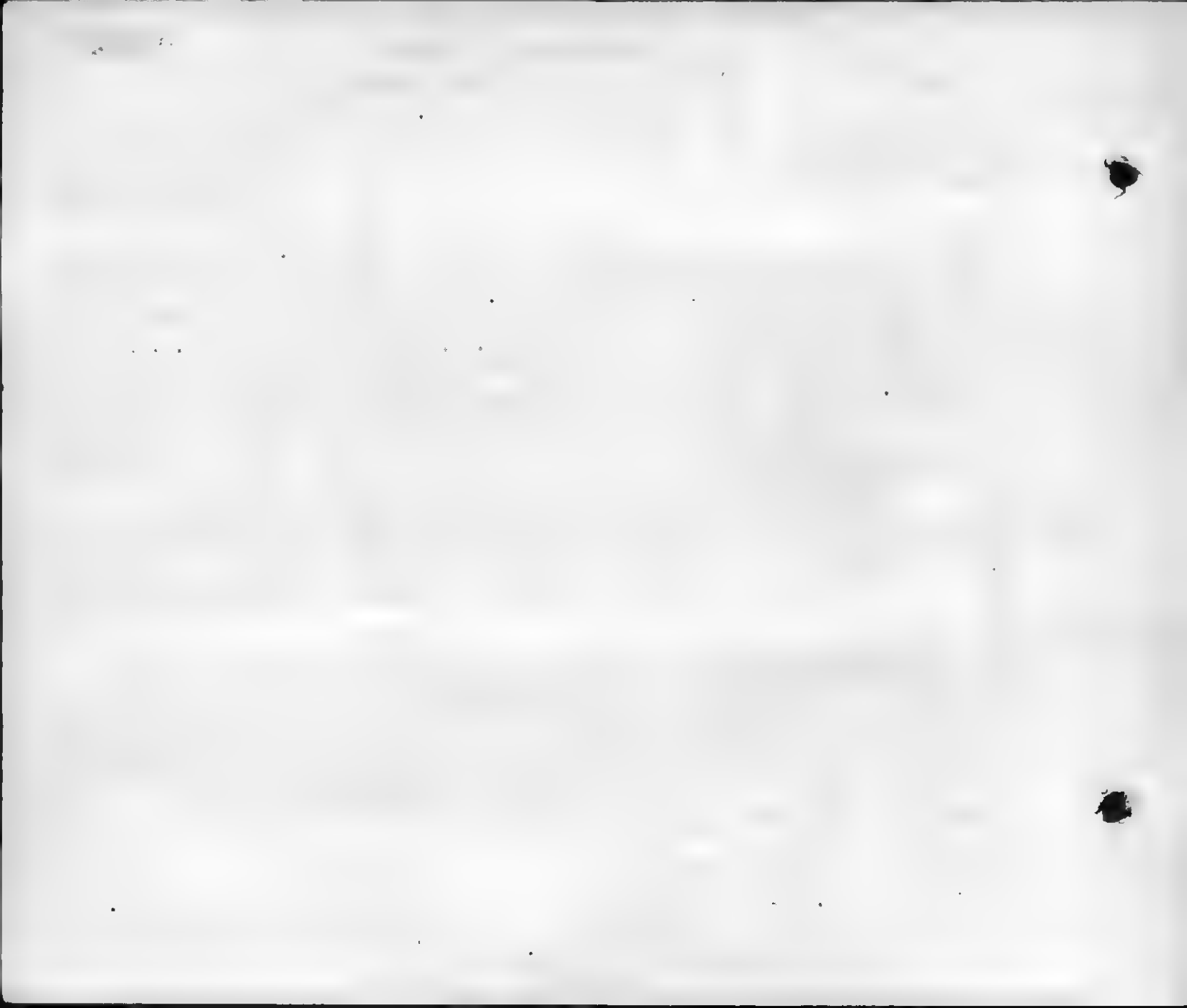
Reg. Dist. No.

00035

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>				c. LENGTH OF STAY IN 1b <b>15 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 Main</b>				d. STREET ADDRESS <b>127 Main</b>			
3. NAME OF DECEASED (Type or print) <b>Mary</b> <b>Florence</b> <b>Harris</b>				4. DATE OF DEATH Jan. 17 1959			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
13. FATHER'S NAME <b>William H. Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Lucindia Ellen (Murphy)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Cardiac Vascular -</b> <b>1st 42X</b> DUE TO <b>Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Murphy Cem</b>		22d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Westernport, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 59</b>		24b. REGISTRAR'S SIGNATURE	

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

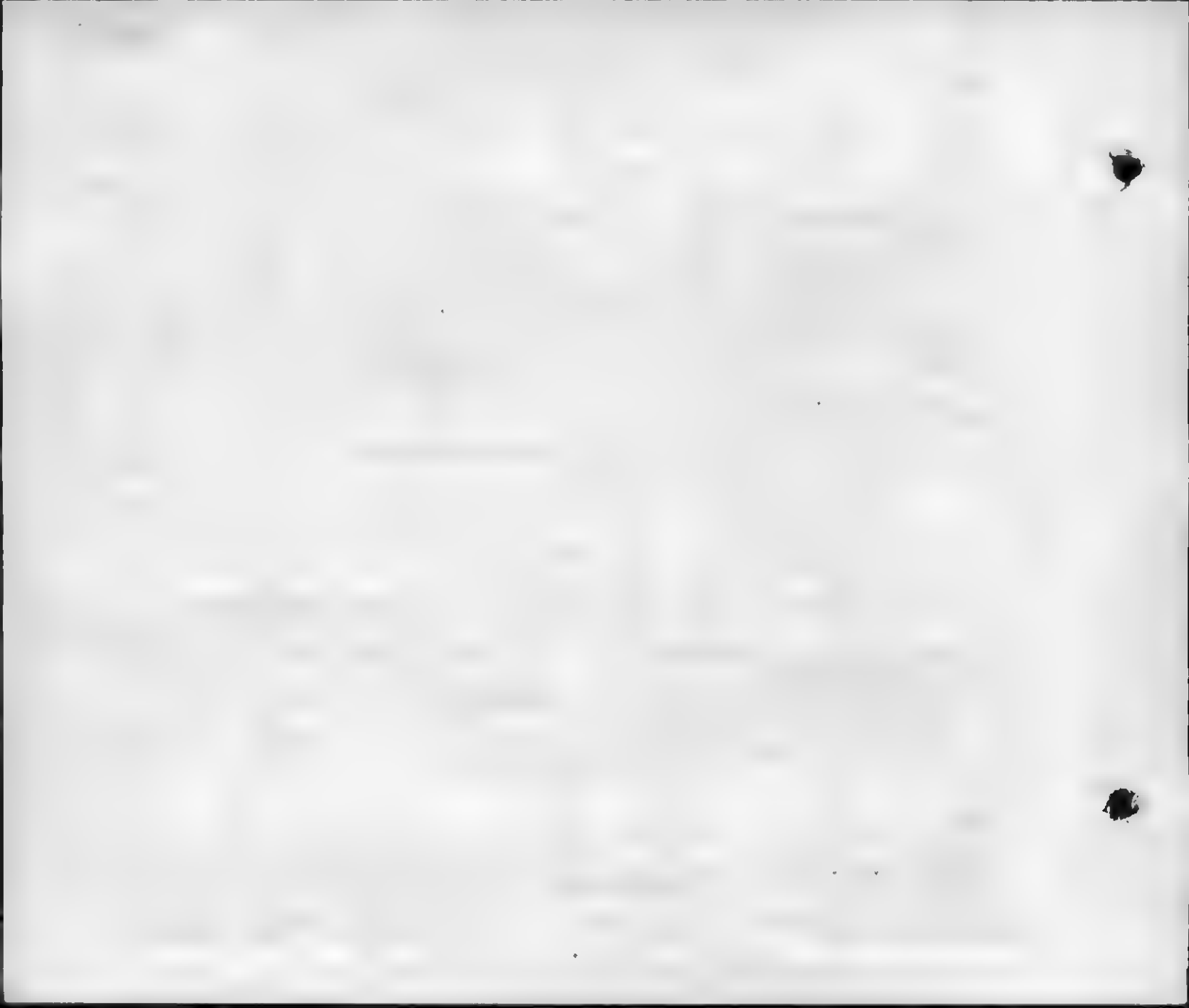


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 4 1-15-59 et  
 93  
 CERTIFICATE OF DEATH

00036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Country Club Road</u>		e. STREET ADDRESS <u>Country Club Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE JOSEPH HARTMAN</u>		4. DATE OF DEATH Month Day Year <u>January 8, 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1917</u>
9. AGE (In years last birthday) yrs <u>41</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Building supplies</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George W. Hartman</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Reilly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>161 14 7345</u>		17. INFORMANT <u>Dorothy Hartman</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/8</u> , 19 <u>59</u> , to <u>1/8</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>1/8</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>[Address]</u>	
PHYSICIAN'S NAME (Type) <u>L. B. Mathews</u>		DATE SIGNED <u>1/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1/12/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington M.C. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Cumberland, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



## 23 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>129 Hanover St.</u>		d. STREET ADDRESS <u>129 Hanover St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Martin</u> Last <u>Hartung</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 1, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brewery Worker German Brewery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward H. Hartung</u>		14. MOTHER'S MAIDEN NAME <u>Magdalena Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-85-5064</u>	
17. INFORMANT <u>Mrs. Louis M. Hartung</u> Address <u>Cumb MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>previous condition</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>1/10/59</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumb Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u> ADDRESS <u>Cumb. MD</u>		24a. REC'D BY REGISTRAR <u>JAN 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>4HRS. 57 MINS</b>		d. STREET ADDRESS <b>704 GEPHART DRIVE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL - MEMORIAL AND WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BABY BOY HILLEARY</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 24 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 24, 1959</b>
9. AGE (In years last birthday) yrs. Months Days <b>4 57</b>		10. IF UNDER 1 YEAR Months Days <b>4 57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>RUSSELL H. HILLEARY JR</b>		14. MOTHER'S MAIDEN NAME <b>ROSE ANN WILLISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown, If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.0 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Summation labor (approx 2 hrs)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumbersland, Md</b>	
21. I certify that I attended the deceased from <b>Jan 24 19 59</b> to <b>Jan 24 19 59</b> , that I last saw the deceased alive on <b>Jan 24 19 59</b> , and that death occurred at <b>Cumbersland, Md</b> , from the causes and on the date stated above.		DATE SIGNED <b>1/24/59</b>	
ACTUAL SIGNATURE <b>W. Royce Hodges</b>		M.D. <b>Cumbersland, Md</b>	
PHYSICIAN'S NAME (Type) <b>W. Royce Hodges</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumbersland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Curtis L. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,



page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



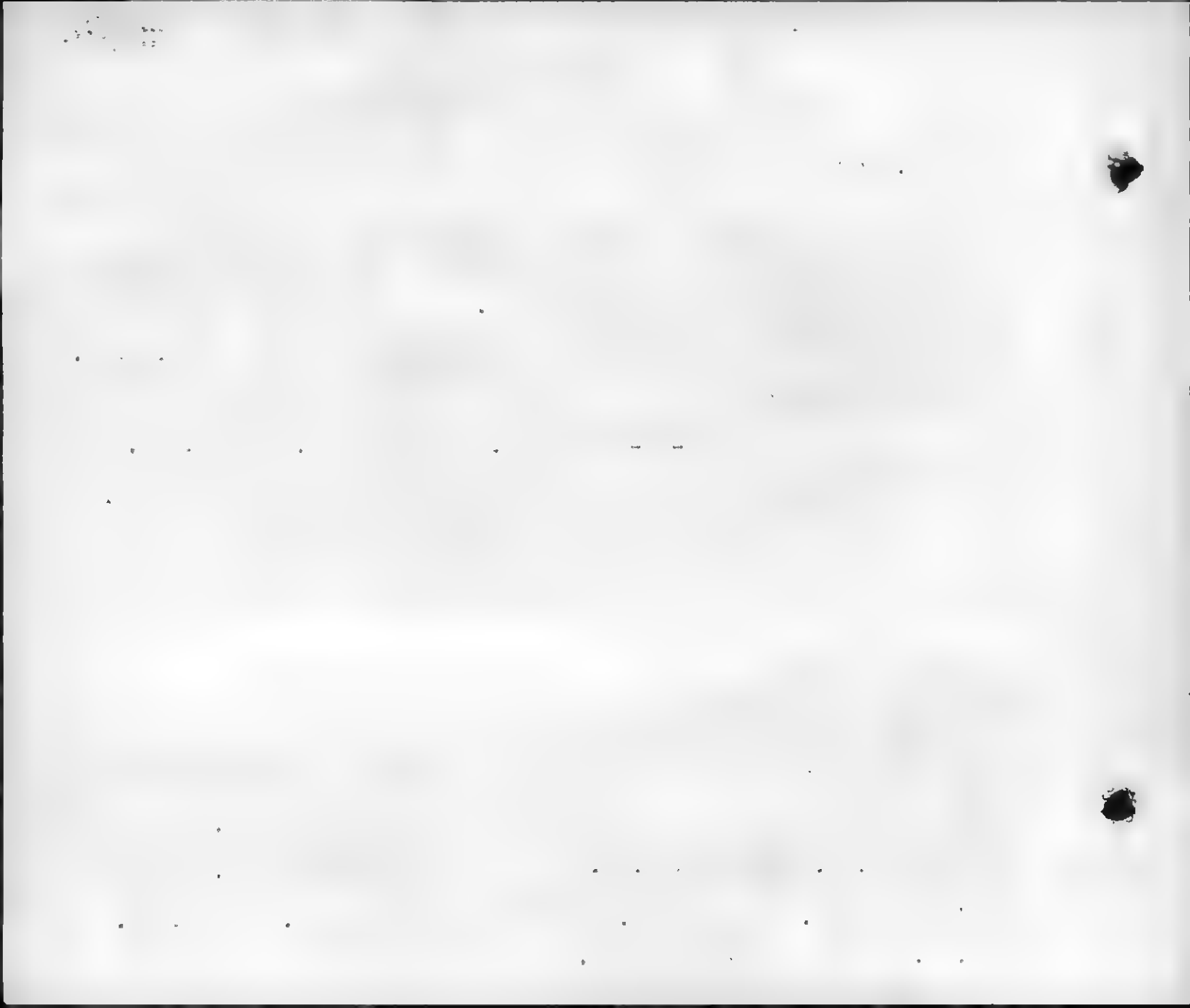
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>HINER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> , Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired boiler maker C &amp; P RR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Hiner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>712-14-1528</b>	
17. INFORMANT <b>Wm. H. Hiner, Mt. Savage, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Fibrosis; Left Bundle Branch Block</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 year ?</b> <b>1 year ?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Lymphatic Leukemia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 12 19 58</b> to <b>January 10 19 59</b> , that I last saw the deceased alive on <b>December 30 19 58</b> , and that death occurred at <b>5:45 A.</b> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>50 Pershing St.,</b> DATE SIGNED			
ACTUAL SIGNATURE  M.D.		ADDRESS (Street, city or town, state) <b>50 Pershing St.,</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>S. B. Jacobson, M. D.</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery, Mt. Savage, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 13 '59</b>		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00040

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN TB <b>40 MINUTES</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. STREET ADDRESS <b>204 LAING AVENUE</b>					
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HORWATH</b> Last <b>HORWATH</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>20</b> Year <b>1959</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 9-1894</b>			
9. AGE (In years last birthday) yrs <b>64</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>DONALD MUDRA</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO <b>none</b>					
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Cumberland, Md.</b>				20g. (County) <b>Cumberland</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Sept 1958</b> , to <b>Jan. 20 1959</b> , that I last saw the deceased alive on <b>Jan. 20 1959</b> , and that death occurred at <b>2:10 P.M.</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Clay E. Durrett</b>				ADDRESS (Street, city or town, state) <b>236 W. 4th Cumberland Md</b>					
DATE SIGNED <b>1/22/59</b>									
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>					
24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>				24b. REGISTRAR'S SIGNATURE <b>C. F. H. Hous</b>					

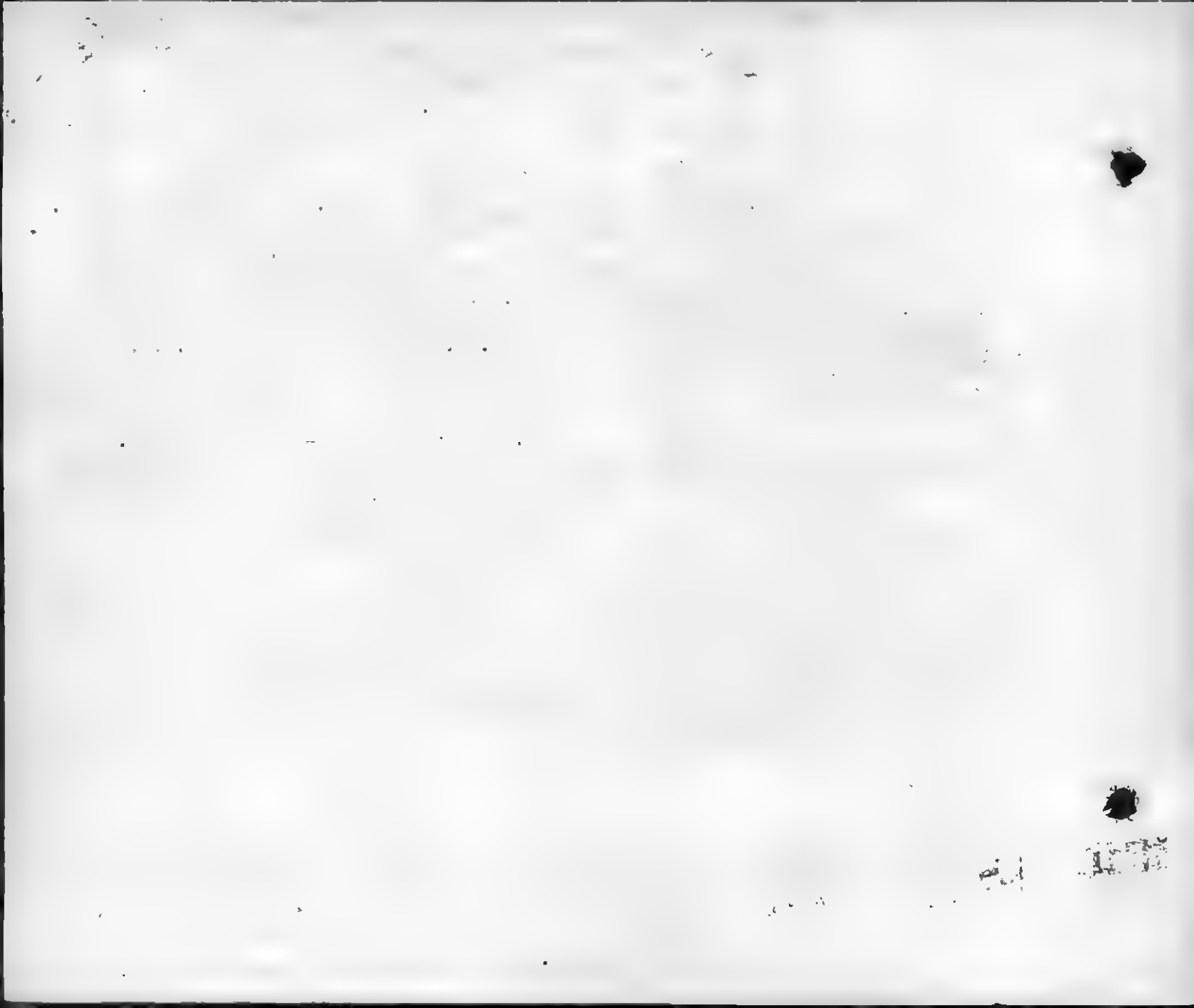


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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>226 Miller St.</b>		e. STREET ADDRESS <b>226 Miller St.</b>	
3. NAME OF DECEASED (Type or print) <b>Sadie</b> First <b>Ann</b> Middle <b>Hott</b> Last		4. DATE OF DEATH <b>Jan.</b> Month <b>21</b> Day <b>1959</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Hme</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Alice Rexroad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-09-3321</b>	
17. INFORMANT <b>Mrs. Stanley Campbell-Westernport, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Heart Disease + Hypertension</b> DUE TO (c) <b>6 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-15</b> , 19 <b>59</b> , to <b>Jan 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 20</b> , 19 <b>59</b> , and that death occurred at <b>2:45</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William W. Loh</b> M.D.		ADDRESS (Street, city or town, state) <b>Westernport, Md.</b>	
PHYSICIAN'S NAME (Type) <b>William Walter Loh</b>		DATE SIGNED <b>1-22-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>	22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boral</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>AN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Hume</b>	

1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. ~~XXXXXXXXXX~~ MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00042

26 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>28 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DARLENE</b> Middle <b>MAY</b> Last <b>JENKINS</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 8-1958</b>	
9. AGE (In years last birthday) <b>5 mos.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>DONALD JENKINS</b>				14. MOTHER'S MAIDEN NAME <b>MABLE HERSHBERGER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>MEMORIAL &amp; WARWICK AVENUES</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> <b>112.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>3 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Dec. 26, 1958</b> , to <b>Jan. 4, 1959</b> , that I last saw the deceased alive on <b>Jan. 4, 1959</b> , and that death occurred at <b>11:36 P.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Dr. R. A. Reiter</b>				ADDRESS (Street, city or town, state) <b>112 Bedford St. Jan. 5, 1959</b>			
PHYSICIAN'S NAME (Type) <b>DR. R. A. REITER</b>				DATE SIGNED <b>Jan. 5, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1-7-59</b>		<b>Davis Memorial Cem.</b>		<b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarcelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. S. Kuma</b>	

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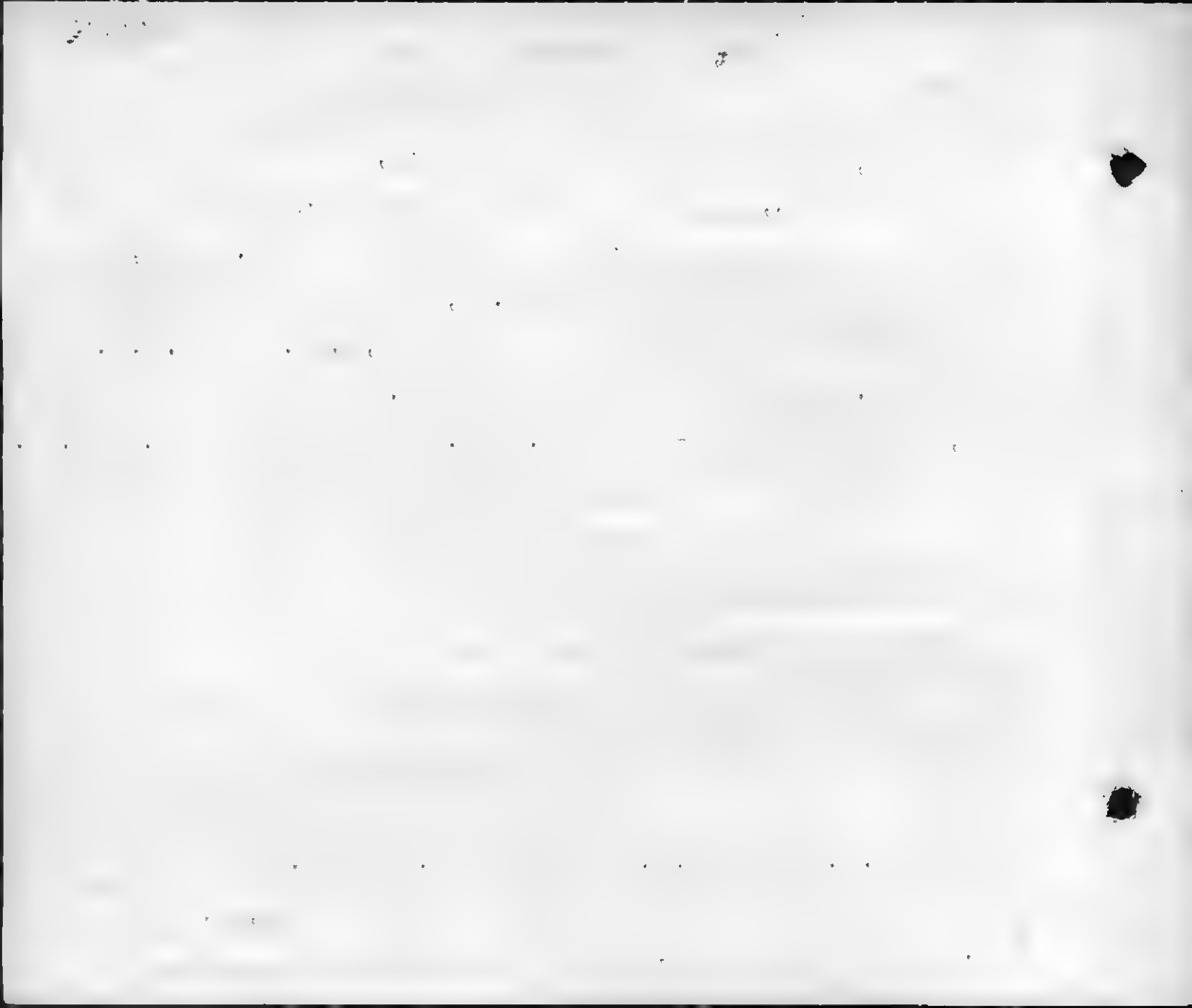
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>609 Piedmont Ave.,</b>		e. STREET ADDRESS <b>609 Piedmont Ave.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Allan</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>10,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert R. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Ettie S. Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>214-07-6270</b>	
17. INFORMANT <b>Mrs. Ada P. Johnson</b>		Address <b>609 Piedmont Ave., Cumb. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> +20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>11.17.1959</b> to <b>Jan. 10, 1959</b> , that I last saw the deceased alive on <b>1-6-1959</b> , and that death occurred at <b>6:30 a.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>H.3.9</b>			
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D.		PHYSICIAN'S NAME (Type) <b>W. F. Williams M. D.</b> <b>122 So. Centre St.,</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 75 CERTIFICATE OF DEATH

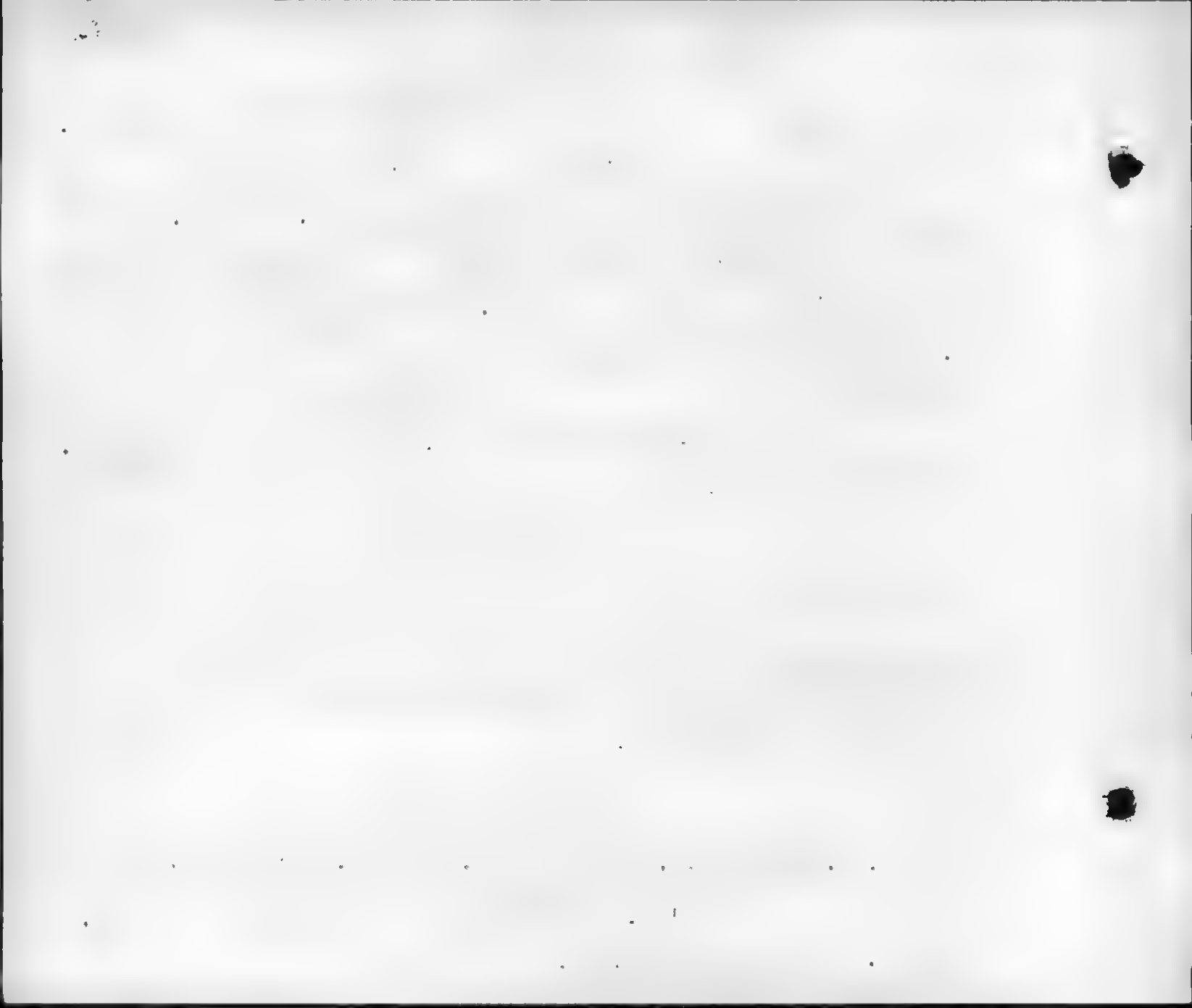
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN tb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John H. Kemp</b>		4. DATE OF DEATH <b>January 29th, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28th, 1866</b>
9. AGE (In years last birthday) <b>92</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Superintendent Sylvan Retreat</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Truman Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Baum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Grant Durst, Frostburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Underwoken by Heart Disease</b> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>1/29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/29</b> , 19 <b>59</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED _____			
ACTUAL SIGNATURE <b>Martin M. Rothstein</b> M.D.		PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein</b> <b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>DATES 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Clifford H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









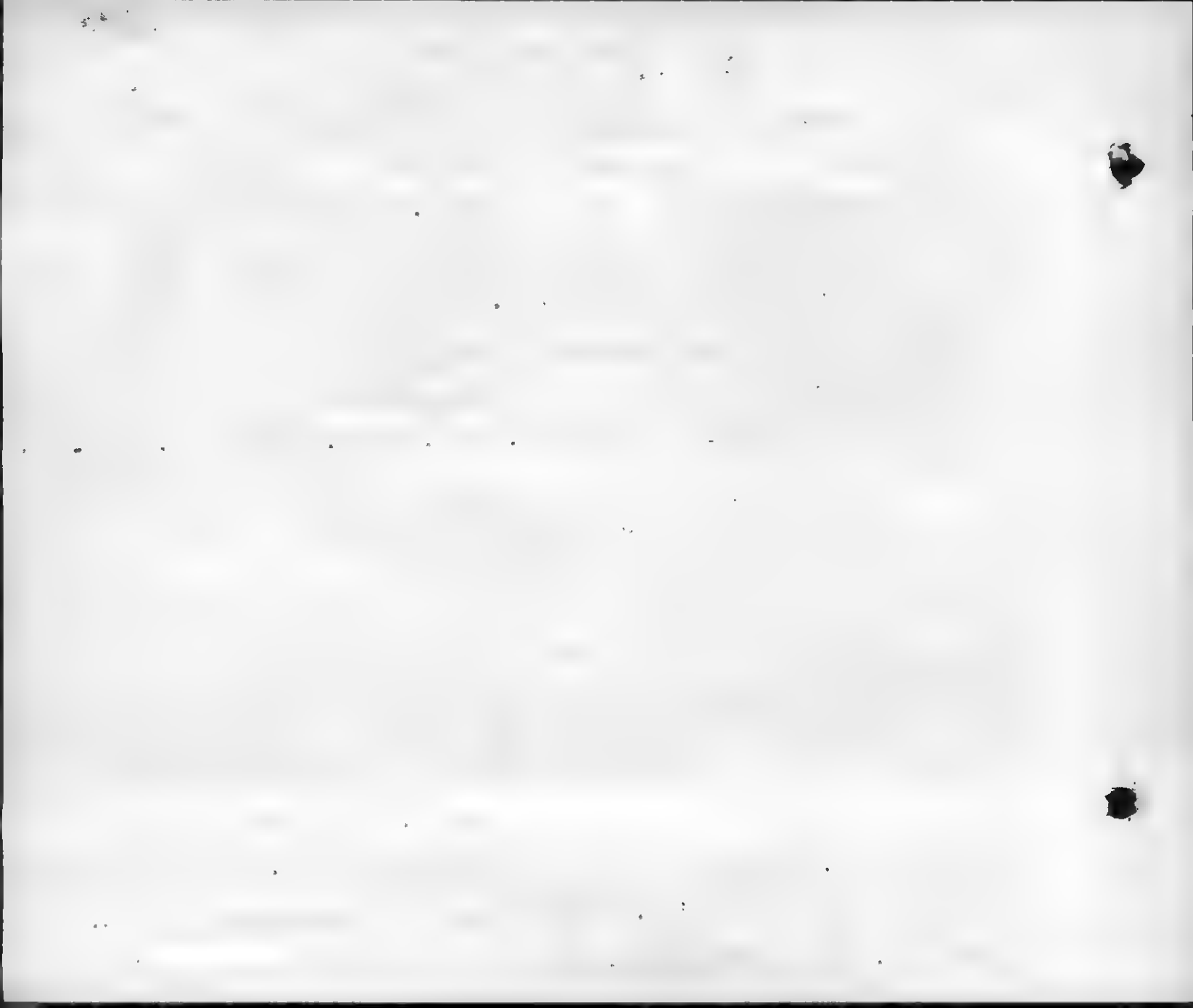
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. STREET ADDRESS <b>80 Mt. Pleasant Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Adkins</b> Last <b>Kerr</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21st, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Samuel Adkins</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>214-01-3780A</b>	
17. INFORMANT <b>Thos. Kerr, 80 Mt. Pleasant St., F'bg., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>RT Hemiplegia</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>Several years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <b>Jan 28, 1959</b> and that death occurred at <b>Jan 29, 1959</b> M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>W. O. McLane</b> M.D.		<b>167 E. Main Street, Jan 30 1959</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane</b>		<b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALONZO</b> Middle <b>E</b> Last <b>KESECKER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 18</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>BERKELEY SPRINGS, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>JACOB KESECKER</b>		14. MOTHER'S MAIDEN NAME <b>EMALINE BECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>705-09-3810</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Penetrated gastric ulcer</b> DUE TO <b>arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility - chronic</b> DUE TO (c) <b>Senility - chronic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 yrs</b> <b>5 days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-8</b> , 19 <b>59</b> , to <b>1-17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-17</b> , 19 <b>59</b> , and that death occurred at <b>8:02 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CUMBERLAND, MARYLAND</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Donald B. Grove</b>		M.D. <b>CUMBERLAND, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DONALD B. GROVE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>B.E.U.B. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Martinsburg, W. Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

29

## CERTIFICATE OF DEATH

00048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>R.</b> Last <b>Keyser</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-84, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia, Ingham Page</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Keyser</b>		14. MOTHER'S MAIDEN NAME <b>Sarah F. Lucas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-9566</b>	
17. INFORMANT <b>Rena Keyser</b>		Address <b>8 Broadway Circle</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Heart Failure - aortic stenosis</b> (c) <b>Arteriosclerosis + Rheumatic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 weeks</b> <b>unknown</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> to <b>1959</b> , that I last saw the deceased alive on <b>1/9</b> 19 <b>59</b> , and that death occurred at <b>10/10/59</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Altoona, Pa.</b> DATE SIGNED <b>1/10/59</b> ACTUAL SIGNATURE <b>S G WEISMAN</b> M.D. PHYSICIAN'S NAME (Type) <b>S G WEISMAN</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR <b>1 3 59</b>	
24b. REGISTRAR'S SIGNATURE <b>James S. King</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Dawson, Md.</i>				c. LENGTH OF STAY IN 1b <i>30 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>McMullen Highway</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rella</i> Middle <i>Rebecca</i> Last <i>Kimble</i>				4. DATE OF DEATH Month <i>January</i> Day <i>12</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 Mar. 1880</i>	9. AGE (In years last birthday) <i>78</i> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 74 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel Van Meter</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Kimble</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Henry Kimble</i>		Address <i>Dawson, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>354x Apoplexy hemiplegia</i> DUE TO (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 hours - 12 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>myocarditis-nephritis chronic</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <i>Jan 12</i> , 19 <i>59</i> , to <i>Jan 12</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 12</i> , 19 <i>59</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>T.C. Giffin</i>		M.D.		KEYSER <i>W. Va.</i>			
PHYSICIAN'S NAME (Type) <i>T.C. Giffin MD.</i>							
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF <i>14 Jan. 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Dawson Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Dawson, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Allen M. Rotruck</i>		ADDRESS <i>Keyser, W. Va.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 15 59</i>	24b. REGISTRAR'S SIGNATURE <i>C. W. H. H. H.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## CERTIFICATE OF DEATH

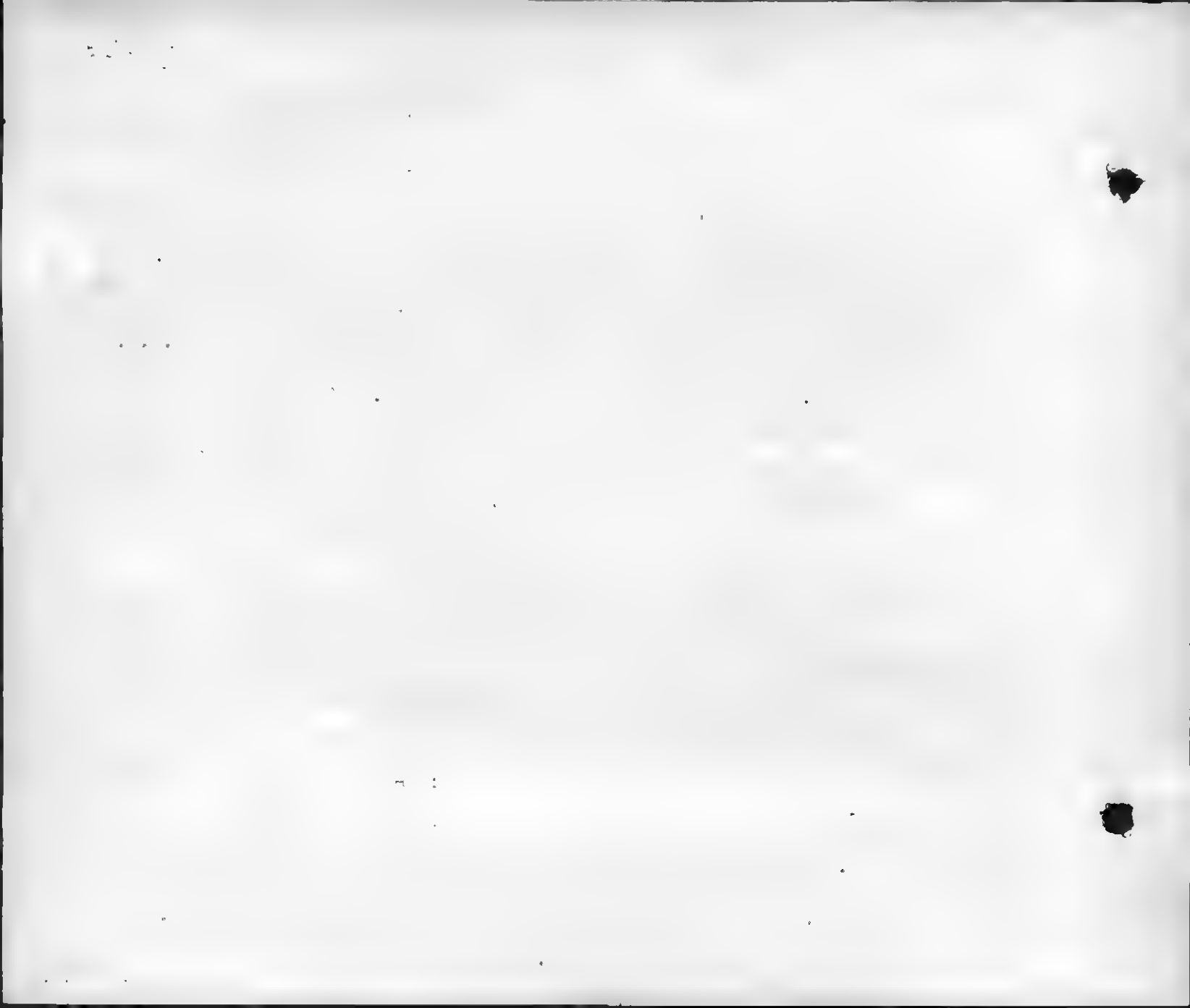
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>15 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DOUGLAS</b> Middle <b>KREGER</b> Last <b>KREGER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 29, 1958</b>		9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>27</b> Hours <b>AM</b>	IF UNDER 24 HRS Hours <b>AM</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ROY J. KREGER</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY T. BISHOP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>492X</b> <b>Atypical Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15 days</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept</b> , 1958, to <b>Jan</b> , 1959, that I last saw the deceased alive on <b>Jan 24</b> , 1959, and that death occurred at <b>1:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Va Ave, Cumberland, Md.</b> DATE SIGNED <b>1/25/59</b> SIGNATURE <b>G. Overton Himmelwright</b> PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 26, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060397XV3



78

## CERTIFICATE OF DEATH

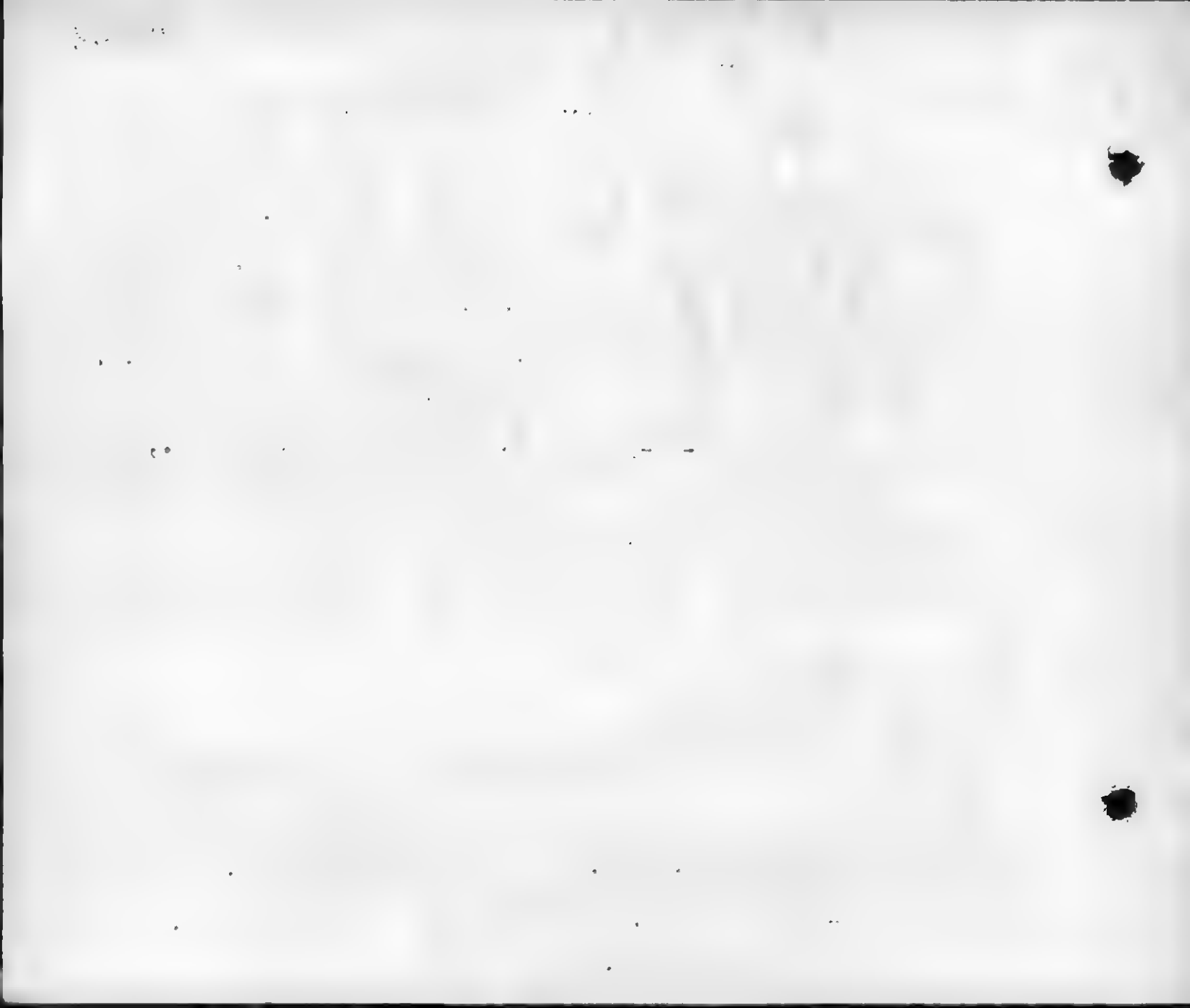
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Mt. Vernon St.</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First <b>J.</b> Middle <b>LACE</b> Last		4. DATE OF DEATH Month <b>Jan.</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1876</b>
9. AGE (In years last birthday) <b>82 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <b>214-07-5030</b>	
17. INFORMANT <b>C. F. Snyder</b>		Address <b>71 Prospect Sq., Cumberland Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 14</b> , 19 <b>59</b> , to <b>Jan 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 18</b> , 19 <b>59</b> , and that death occurred at <b>8:00 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Broadway,</b> DATE SIGNED ACTUAL SIGNATURE <b>John B. Davis</b> , M.D. PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b> <b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>L. K. K.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



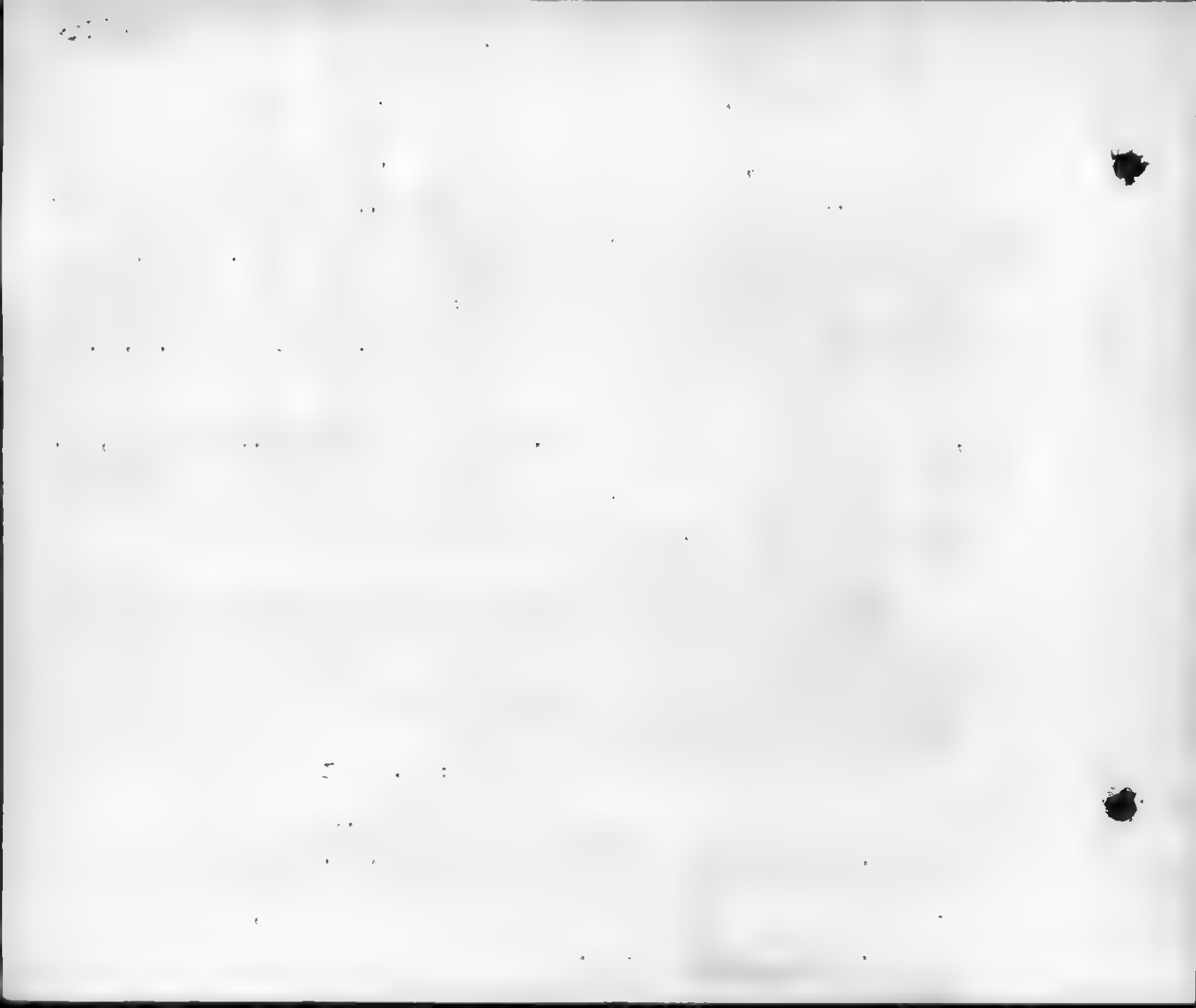
## 31 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>201 Paca St.,</b>		d. STREET ADDRESS <b>201 Paca St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pierce</b> Middle <b>Augustus</b> Last <b>Lacy</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>23,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1872</b>
9. AGE (In years last birthday) <b>86</b> ym.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing &amp; Heating</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Lacy</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. <b>Address</b> <b>Mrs. Maude Lacy 201 Paca St., Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>chronic nephritis</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 years</b> <b>4 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-2, 1957</b> to <b>1-23, 1959</b> , that I last saw the deceased alive on <b>1-22-1959</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>57 Greene St.,</b> DATE SIGNED ACTUAL SIGNATURE <b>L Brings</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Lewis Brings</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert A. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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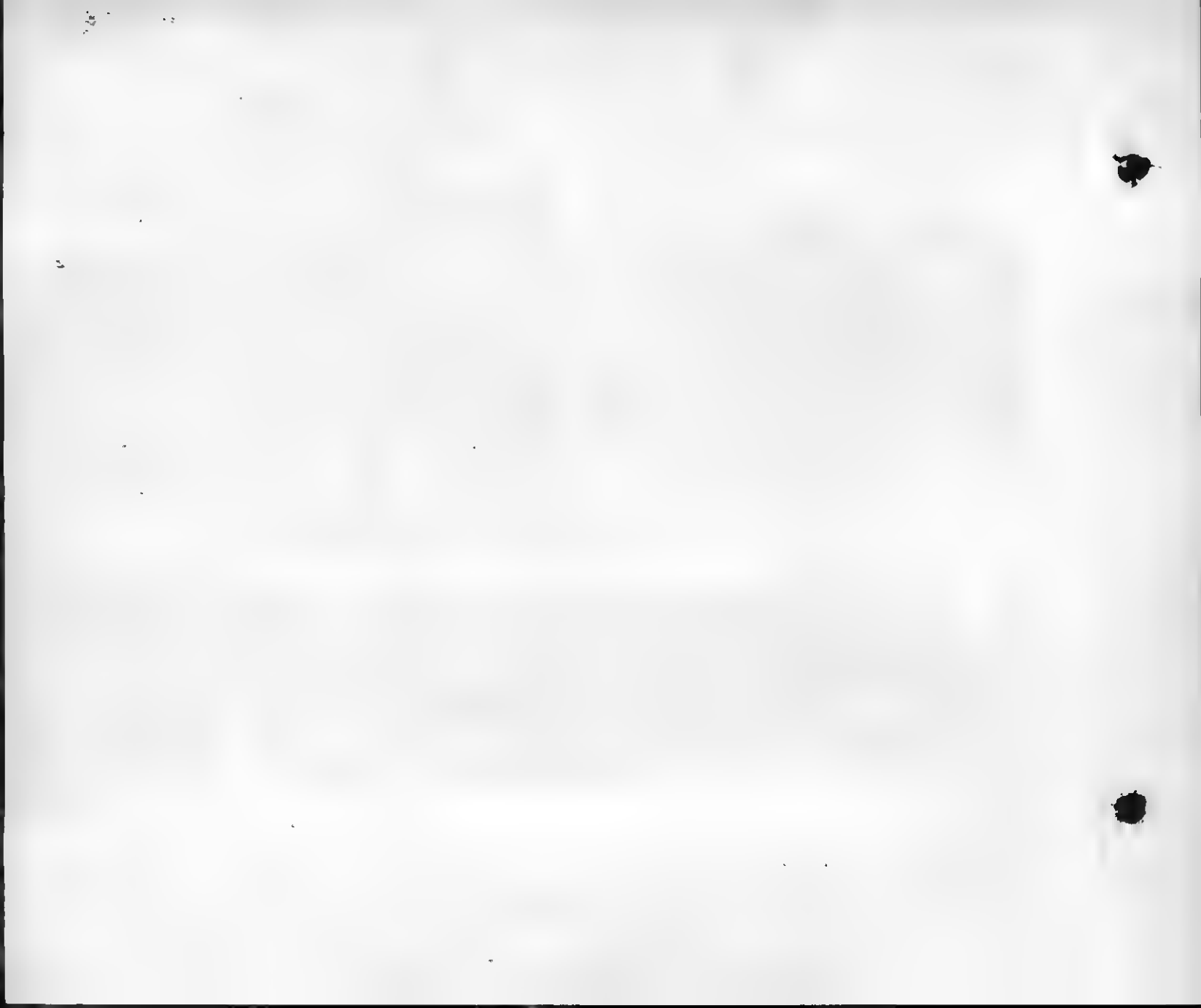
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>131 Grand Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
f. STREET ADDRESS <b>131 Grand Ave.</b>		g. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rhoda Elnore Leasure</b>		4. DATE OF DEATH Jan. 9, 1959	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1876</b>
9. AGE (In years last birthday) yrs <b>82</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Magnolia, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Gross</b>		14. MOTHER'S MAIDEN NAME <b>Mary Goldizen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John H. Leasure, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>10 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/8/56</b> 19 to <b>1/9/59</b> 19, that I last saw the deceased alive on <b>1/5/59</b> 19, and that death occurred at <b>3:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>1-10-59</b>			
ACTUAL SIGNATURE <b>R. J. Williams</b>		PHYSICIAN'S NAME (Type) <b>Dr. R. J. Williams</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>James F. Scarpelli</b>	
24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>(BARNARD)</u> Last <u>LEWIS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Barnard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>214-01-6653D</u>	
17. INFORMANT <u>Rouben Lewis,</u>		Address <u>Eckhart, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma sigmoid</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14, 1958</u> to <u>Jan 3, 1959</u> , that I last saw the deceased alive on <u>Jan 3, 1959</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>E. Main St., Frostburg, Md.</u> DATE SIGNED <u>Jan 3, 1959</u>			
ACTUAL SIGNATURE <u>W. O. McLane</u> M. D.		PHYSICIAN'S NAME (Type) <u>W. O. McLane, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kuma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72-hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

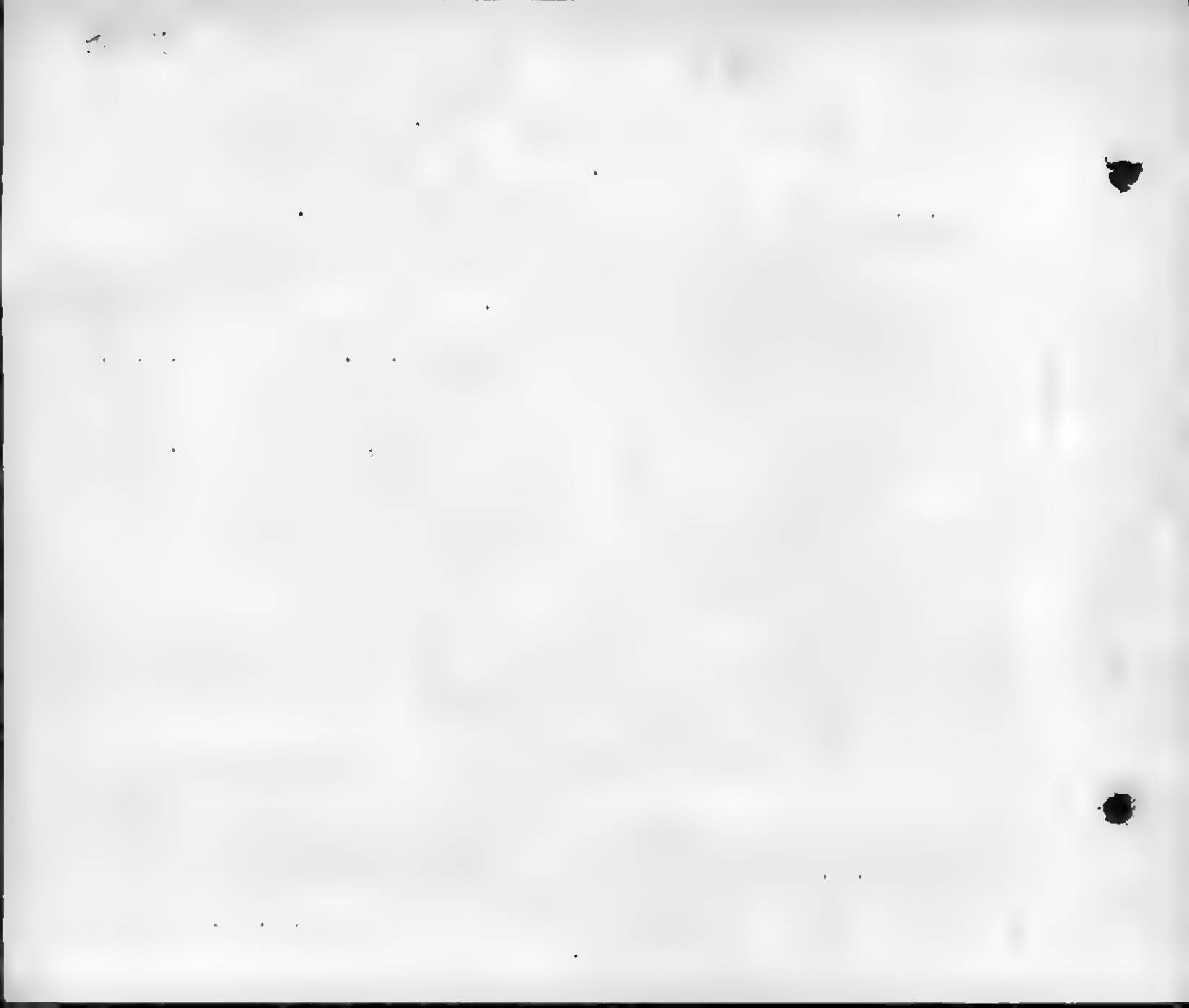
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FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> <span style="float: right;">b. COUNTY <u>Clay</u></span>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>North Kansas City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. at Sacred Heart Hospital</u>			d. STREET ADDRESS <u>1400 East 22nd Ave.</u>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Sarah</u> Middle <u>Anna</u> Last <u>Martin</u>			<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>31</u> Year <u>1959</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Nov. 9, 1883</u>		9. AGE (in years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Elkins, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>John Hyatt</u>		
14. MOTHER'S MAIDEN NAME <u>Amanda (unknown)</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>No</u>			17. INFORMANT <u>Mrs Henry DeHaven, Cresaptown, Md.</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (c) stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>B. Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 1, 1959</u>			
EXAMINER'S NAME (Type) <u>Dr. B. Skitarelic</u>		22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>Feb. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Paw Paw W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 3 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 HRS. 33 MIN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
		f. STREET ADDRESS <b>212 SCHLEY STREET</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>HORTENSE</b> Last <b>MAXWELL</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1889</b>
9. AGE (In years last birthday) yrs <b>69</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Sect.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEO. CREEK COAL CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA (SOMERSET, CO.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH S. MAXWELL</b>		14. MOTHER'S MAIDEN NAME <b>EMMA MARY FAIDLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-6973</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>		<b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiovascular Disease</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b> 10 yr 10 yr 10 yr		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>10 yr</b> <b>10 yr</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Central Nervous System</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 55</b> to <b>1/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/17</b> , 19 <b>59</b> , and that death occurred at <b>11:53 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Weissman</b>		ADDRESS (Street, city or town, state) <b>59 Greene St. Cumberland, Md.</b>	
DATE SIGNED <b>1/18/59</b>			
PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 21, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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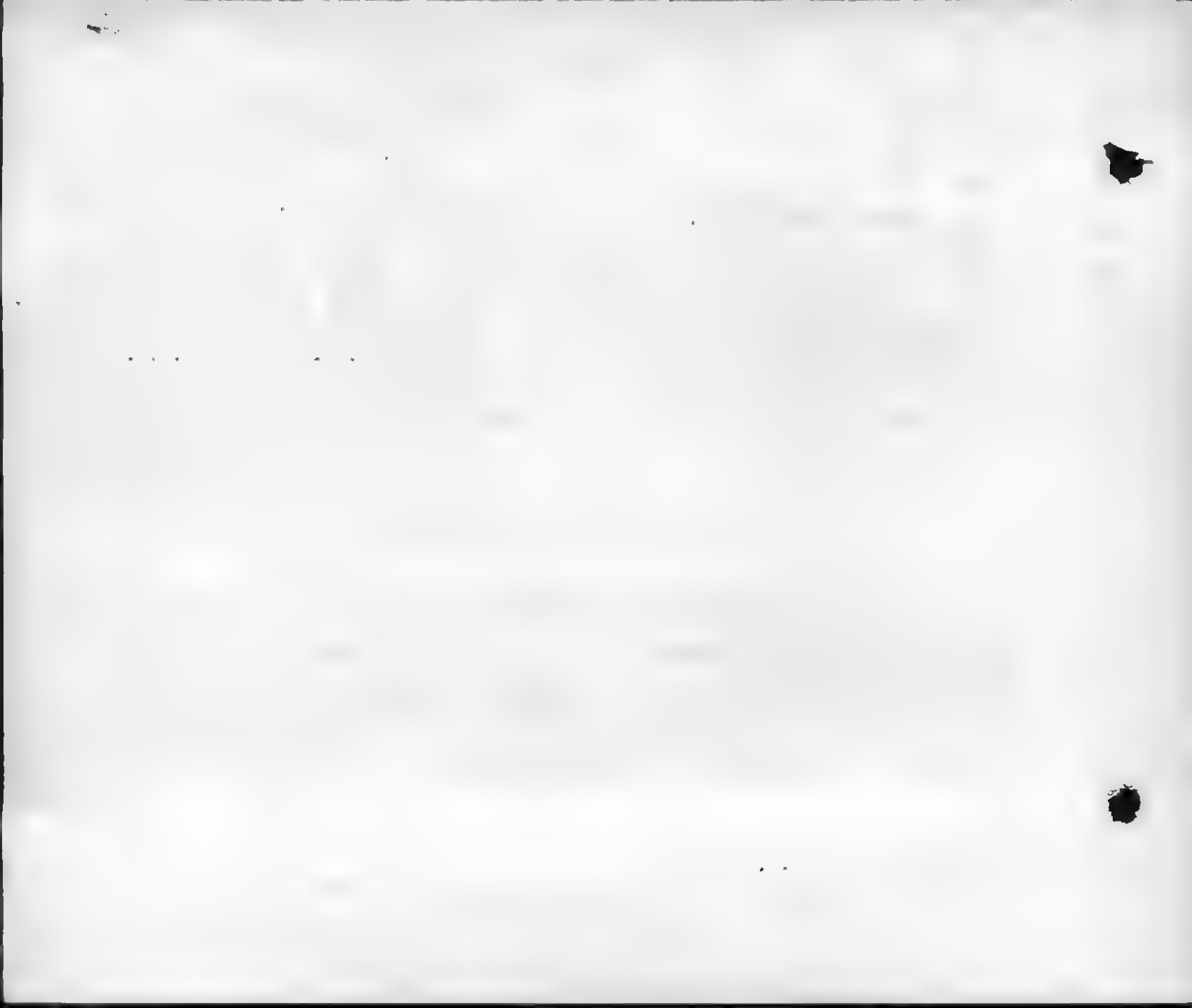
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>MARYLAND</b> b COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>42 DAYS</b>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>E</b> Last <b>MC FARLAND</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 13 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b>	
11. BIRTHPLACE (State or foreign country) <b>GRAFTON, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES MC FARLAND</b>		14. MOTHER'S MAIDEN NAME <b>PEARL DAVIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>705-03-8390</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Brochitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/22/58</b> 19, to <b>1/3/59</b> 19, that I last saw the deceased alive on <b>4/3/59</b> 19, and that death occurred at <b>12:55 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>CUMBERLAND, MD.</b> DATE SIGNED <b>1/3/59</b>			
ACTUAL SIGNATURE <b>R.J. WILLIAMS</b>		M.D. <b>CUMBERLAND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





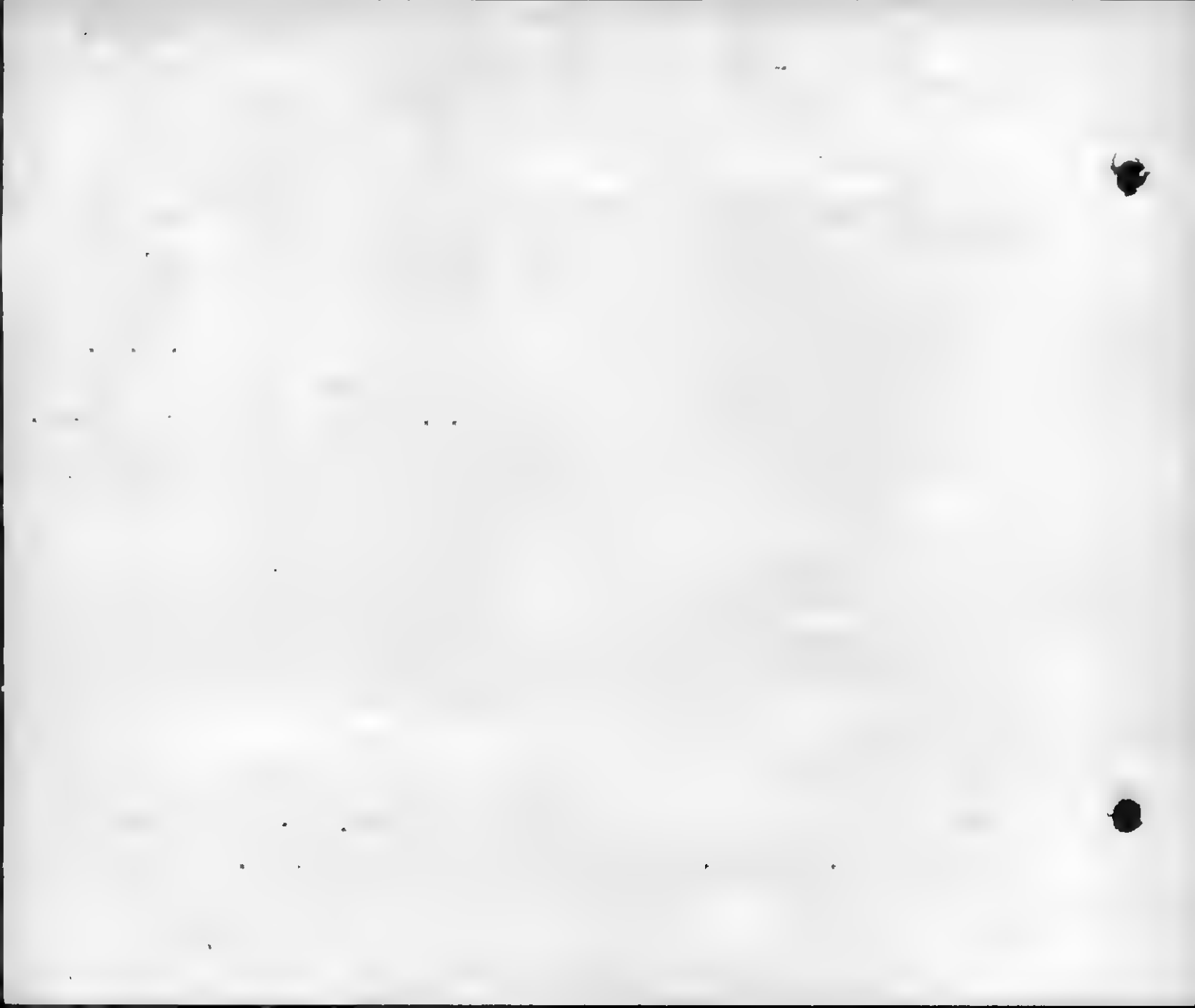
36

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12/18/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
f. STREET ADDRESS <b>541 Arnette Terrace</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Estella</b> Middle <b>Middleton</b> Last <b>Middleton</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/1878</b>
9. AGE (In years last birthday) yrs <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Allan Teets</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>		18. <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypertension</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Chronic Myocarditis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/18/58</b> , 19 to <b>1/21/59</b> , 19, that I last saw the deceased alive on <b>1/21/59</b> , 19, and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean, M.D.</b>		ADDRESS (Street, city or town, state) <b>49 Green St.</b> DATE SIGNED <b>1/22/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DAIAN 27 59</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

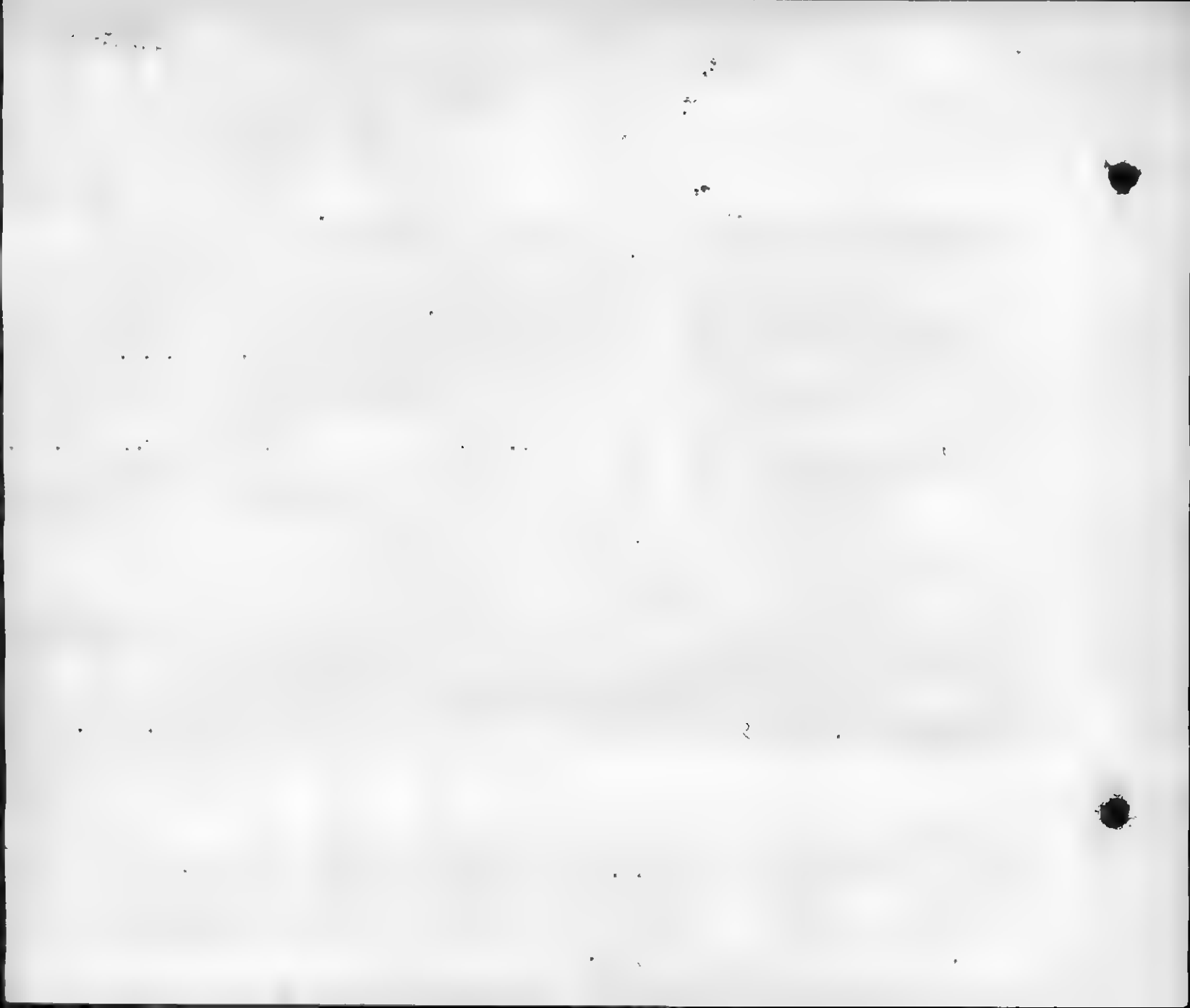
00059

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. STREET ADDRESS <u>216 Decatur St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Ethel</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>1/4</u> Day <u>5</u> Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1918</u>
9. AGE (In years last birthday) <u>40</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>0</u> Hours <u>0</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer in coning</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Silk business</u>	
11c. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Marston</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Mrs. Victor McCauley</u>		Address <u>417 Walnut St., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of Brain; Intracranial Hemorrhage</u>            DUE TO            (b) <u>Skull Fracture</u>            DUE TO            (c) _____            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>  <u>3 Days</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Struck on Head with Blunt Instrument</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:00</u> a. m. <u>Jan. 1</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland Alleg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarolic</u>		DATE SIGNED <u>January 4, 1959</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarolic, M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Jan 6 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

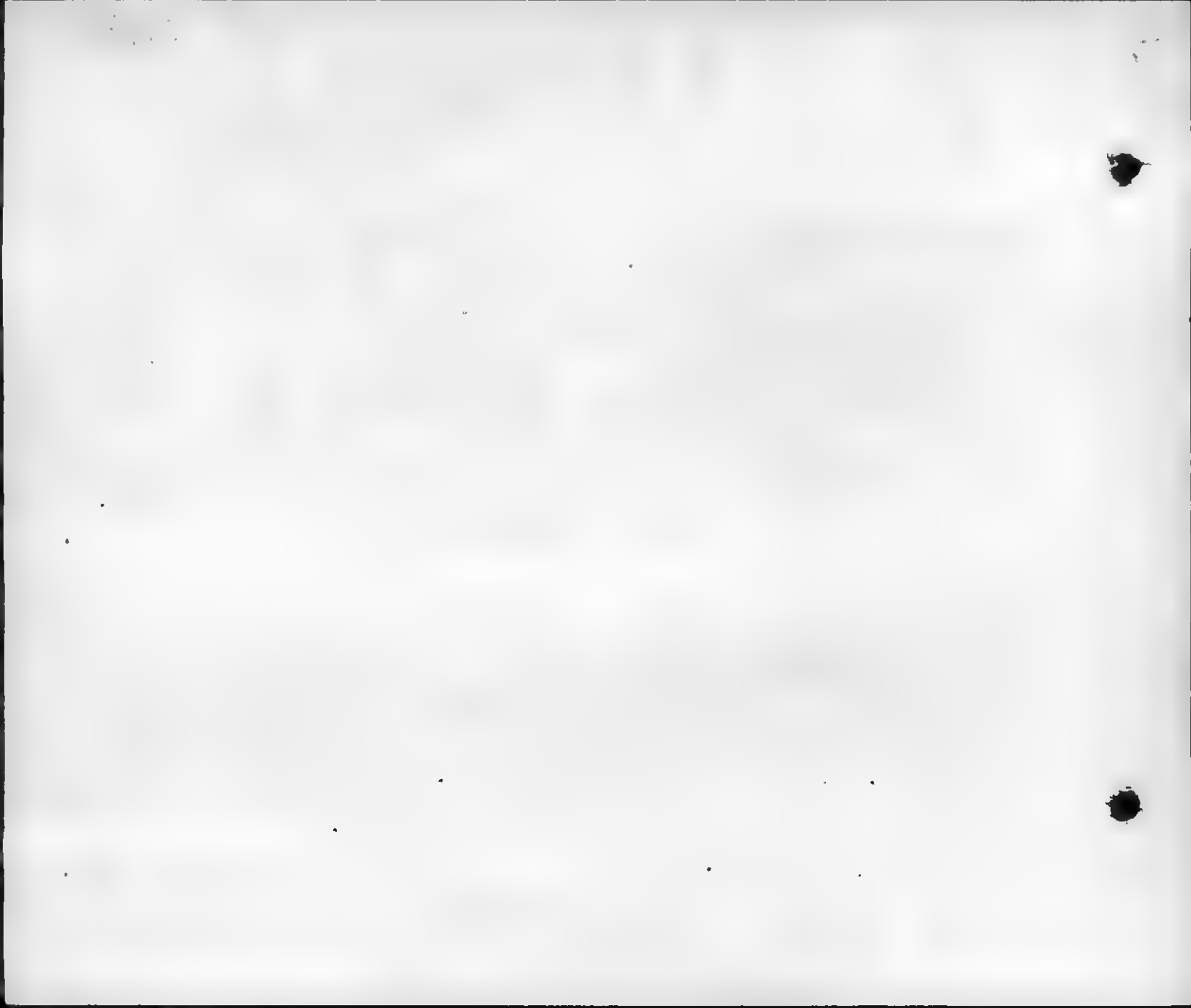


## 38 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 Month 13 days</u> <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>508 Columbia Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>F.</u> Last <u>Molinari</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-93</u>	
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar-Tender at Cadillac Lounge</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank Molinari (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Josephine- Santelli</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>420-07-6823</u>			
17. INFORMANT <u>Patient's Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>2 weeks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 27, 19 58</u> to <u>January 25, 19 59</u> , that I last saw the deceased alive on <u>Jan. 25, 19 59</u> , and that death occurred at <u>8.27 AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>J. P. Hallinan M.D.</u>				ADDRESS (Street, city or town, state) <u>140 Bedford St., Cumberland, Md.</u>			
DATE SIGNED <u>1/26/59</u>							
PHYSICIAN'S NAME (Type) <u>J. P. Hallinan M.D.</u>				<u>140 Bedford Street, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 20 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight.</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



39

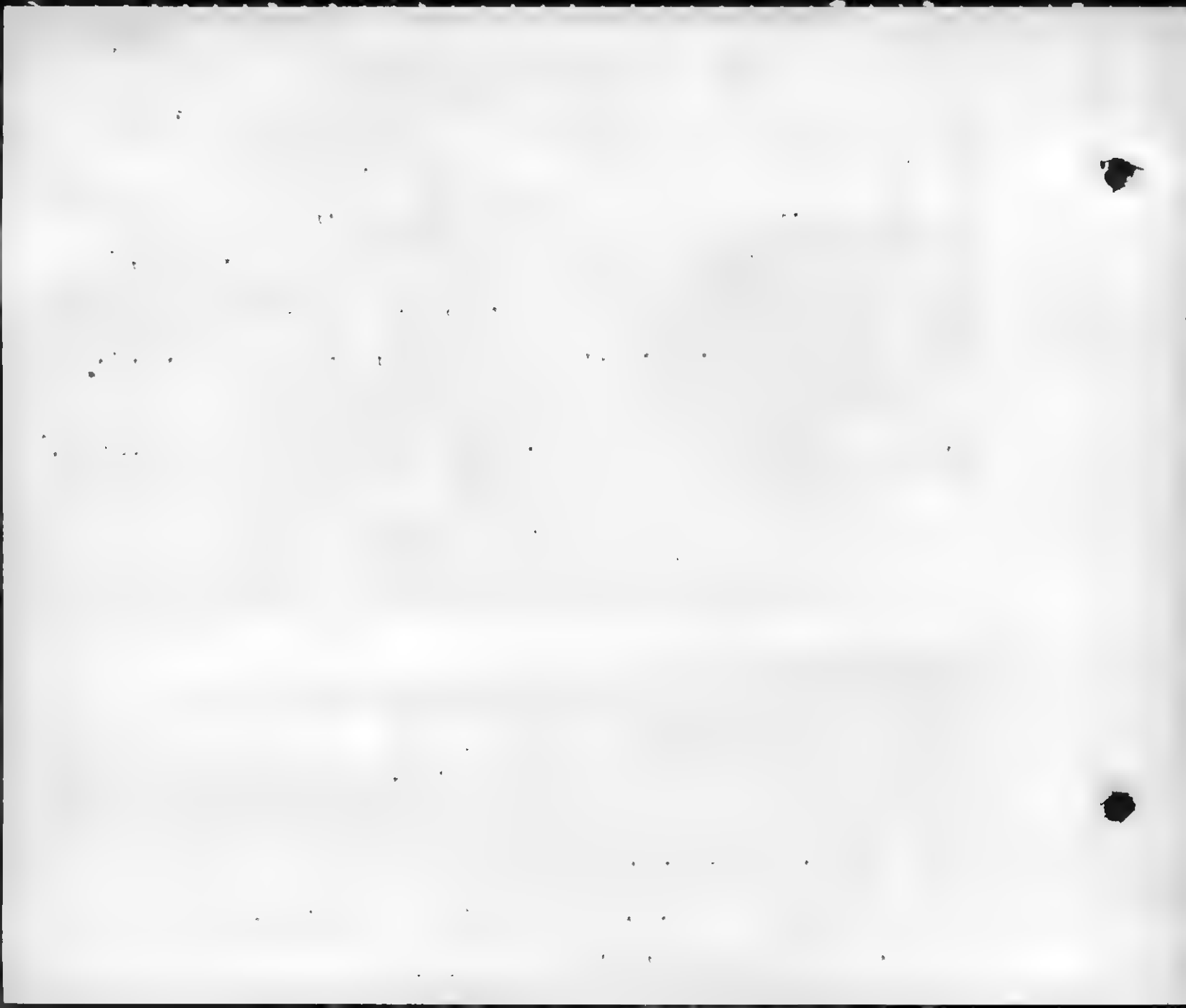
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Harrison St.,</b>		d. STREET ADDRESS <b>115 Harrison St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Francis</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>22,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. MONTHS <b></b> Days <b></b> Hours <b></b> Min <b></b>	11. IF UNDER 1 YEAR <b></b> IF UNDER 24 HRS <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>Patrick Moore</b>	
14. MOTHER'S MAIDEN NAME <b>Bridget Hefren</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No,</b>	
16. SOCIAL SECURITY NO <b></b>		17. INFORMANT <b>Mrs. Catherine Moore</b> Address <b>115 Harrison St., Cumb. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thaemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Lymphatic Leukemia</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 15, 1958</b> to <b>Jan. 21, 1959</b> , that I last saw the deceased alive on <b>Jan. 21, 1959</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D. <b>236 W. 1st Cumberland</b>		DATE SIGNED <b>1/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul's</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

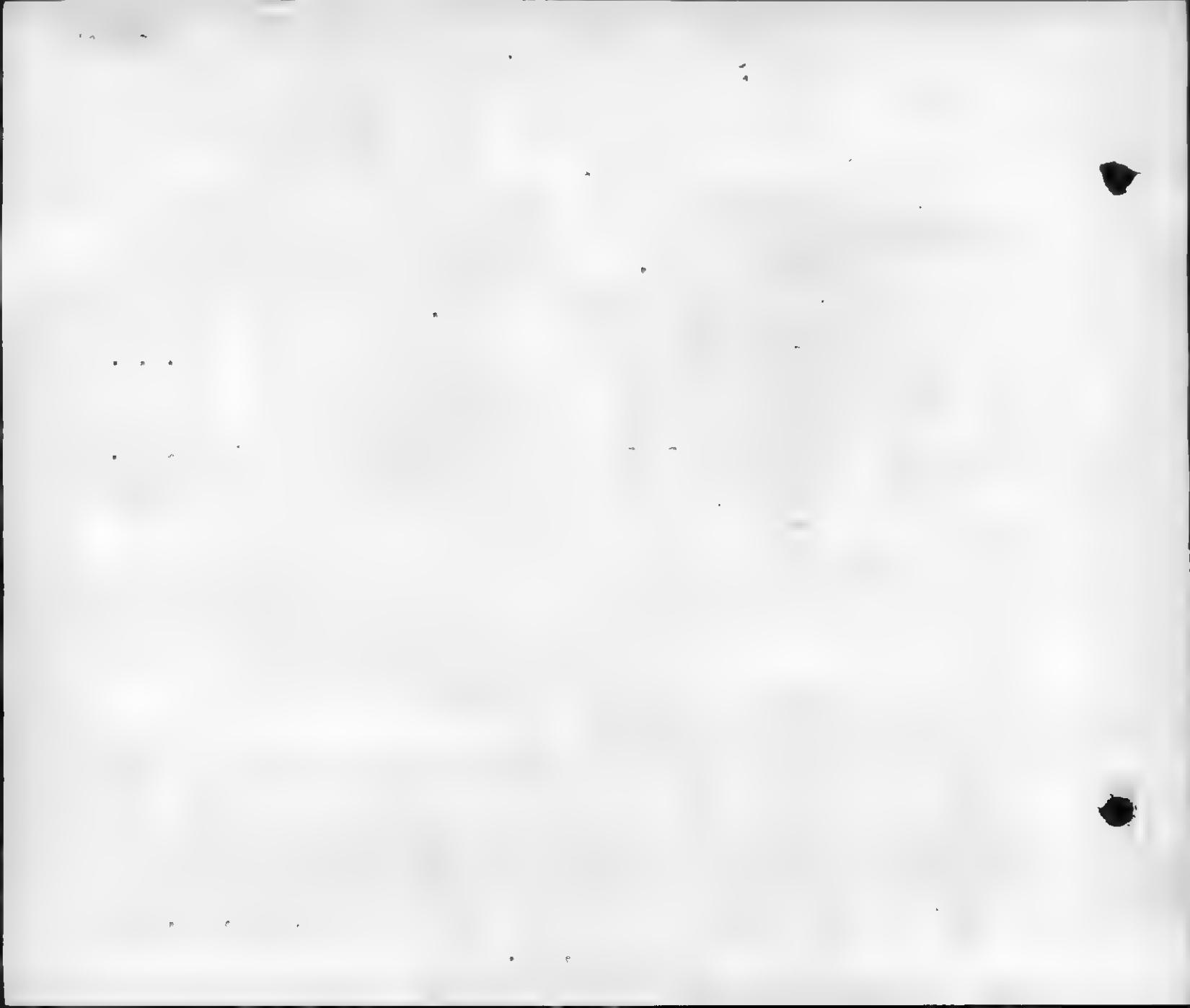
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Lonaconing</b>	
c. LENGTH OF STAY IN 1b <b>66yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Street</b>		e. STREET ADDRESS <b>Union Street</b>	
3. NAME OF DECEASED (Type or print) <b>ELLSWORTH A. MORTON</b>		4. DATE OF DEATH <b>Jan 25 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1892</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>25</b> Days <b>5</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Morton</b>		14. MOTHER'S MAIDEN NAME <b>Jane Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>182-01-3563</b>	
17. INFORMANT <b>Robert Morton</b>		Address <b>Lonaconing, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.O. Mc Lane</b>		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W.O. Mc Lane MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		ADDRESS <b>LONA CONING, MD.</b>	
24a. REC'D BY REGISTRAR <b>Jan 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford E. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



40

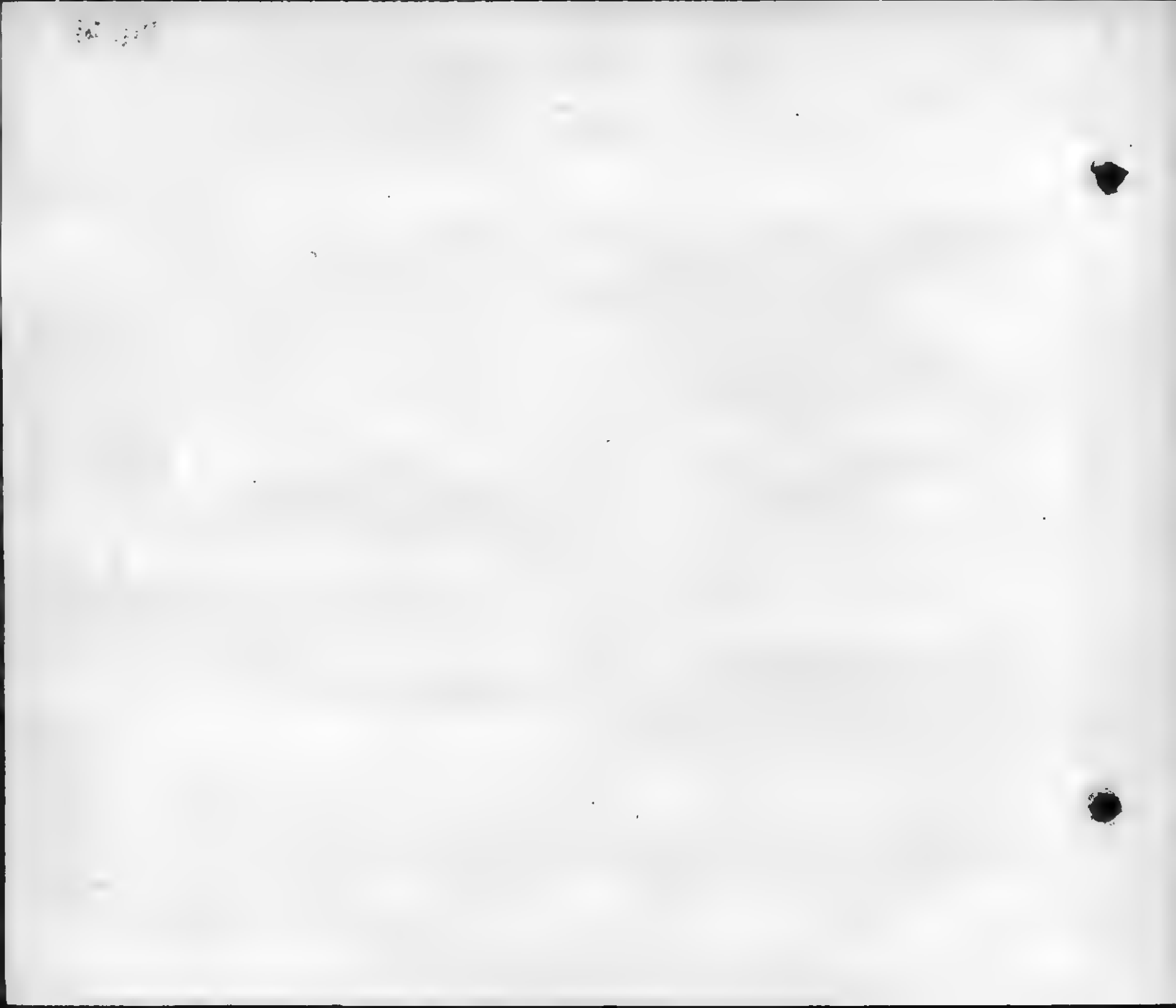
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b <i>Ind</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>501 Magnuder St.</i>		d. STREET ADDRESS <i>501 Magnuder St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Loretto</i> Middle <i>Mullaney</i> Last <i>Mullaney</i>		4. DATE OF DEATH Jan 20, 1959	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 27, 1872</i>
9. AGE (in years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Mt Savage Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas Malloy</i>	
14. MOTHER'S MAIDEN NAME <i>Ellen Logsdon</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO <i>none</i>		17. INFORMANT <i>Mrs. Alice Schellhaus</i> Address <i>Cumb-192</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Renal failure</i> DUE TO (b) <i>arterio Sclerosis Endarteritis</i> DUE TO (c) <i>diabetes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> 19 <i>08</i> , to <i>Jan 20</i> 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 20</i> 19 <i>59</i> , and that death occurred at <i>1301</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cumberland</i> DATE SIGNED			
ACTUAL SIGNATURE <i>J. C. Russell</i> M.D.		PHYSICIAN'S NAME (Type) <i>Cumberland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/23/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt Patricks Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Mt Savage Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc</i> ADDRESS <i>Cumb Md</i>		24a. REC'D BY REGISTRAR DATE JAN 26 1959	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

00064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>516 HILL STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JONAS</b> Middle <b>Myers</b> Last <b>Myers</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>15</b> Year <b>-59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>(C)</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 5, 1883</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Step-Father John Bailes</b>		14. MOTHER'S MAIDEN NAME <b>Clara (Hickman)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-2642</b>	
17. INFORMANT <b>STEP SON ROLAND</b>		Address <b>Cumbr. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Coronary Insufficiency (acute)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>??</b> <b>1/7/59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Arteriosclerosis - Pulmonary Embolism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/7/59</b> , 19 <b>59</b> , to <b>1/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/15/59</b> , 19 <b>59</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 PERSHING ST CUMBERLAND MD</b> DATE SIGNED <b>1/16/59</b>			
ACTUAL SIGNATURE <b>Samuel Jacobson</b>		M.D. <b>Samuel Jacobson, M.D.</b>	
PHYSICIAN'S NAME (Type)		CUMBERLAND MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Buried</b>		<b>1/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Sumner Cem.</b>		<b>Cumbr. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Louis Allen Inc</b>		<b>Cumbr. Md</b>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<b>JAN 20 1959</b>		<b>Richard S. Kline</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.



## 42 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Nelson</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>19 59</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Mar. 31, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Kelly Springfield Eckhart Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Nelson</u>		14 MOTHER'S MAIDEN NAME <u>Rosa Crowe</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-05-9697</u>	
17 INFORMANT <u>Mrs. John Reed</u>		23 Address <u>223 Charles St. Cumberland Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>222-242-420</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>58</u> , to <u>1/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>59</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>456 N. Centre Street Cumberland, Md.</u> DATE SIGNED <u>1/31/59</u>	
PHYSICIAN'S NAME (Type) <u>Leo H. Ley Jr. M.D.</u>		22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2/2/59</u>	
22c NAME OF CEMETERY OR CREMATORY <u>St. George's Ep. Cemetery</u>		22d LOCATION (City, town, or county) <u>Allegany</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hager</u> ADDRESS <u>Cumberland Md</u>		24a REC'D BY REGISTRAR <u>FEB 6 '59</u> 24b REGISTRAR'S SIGNATURE <u>C. J. Hager</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





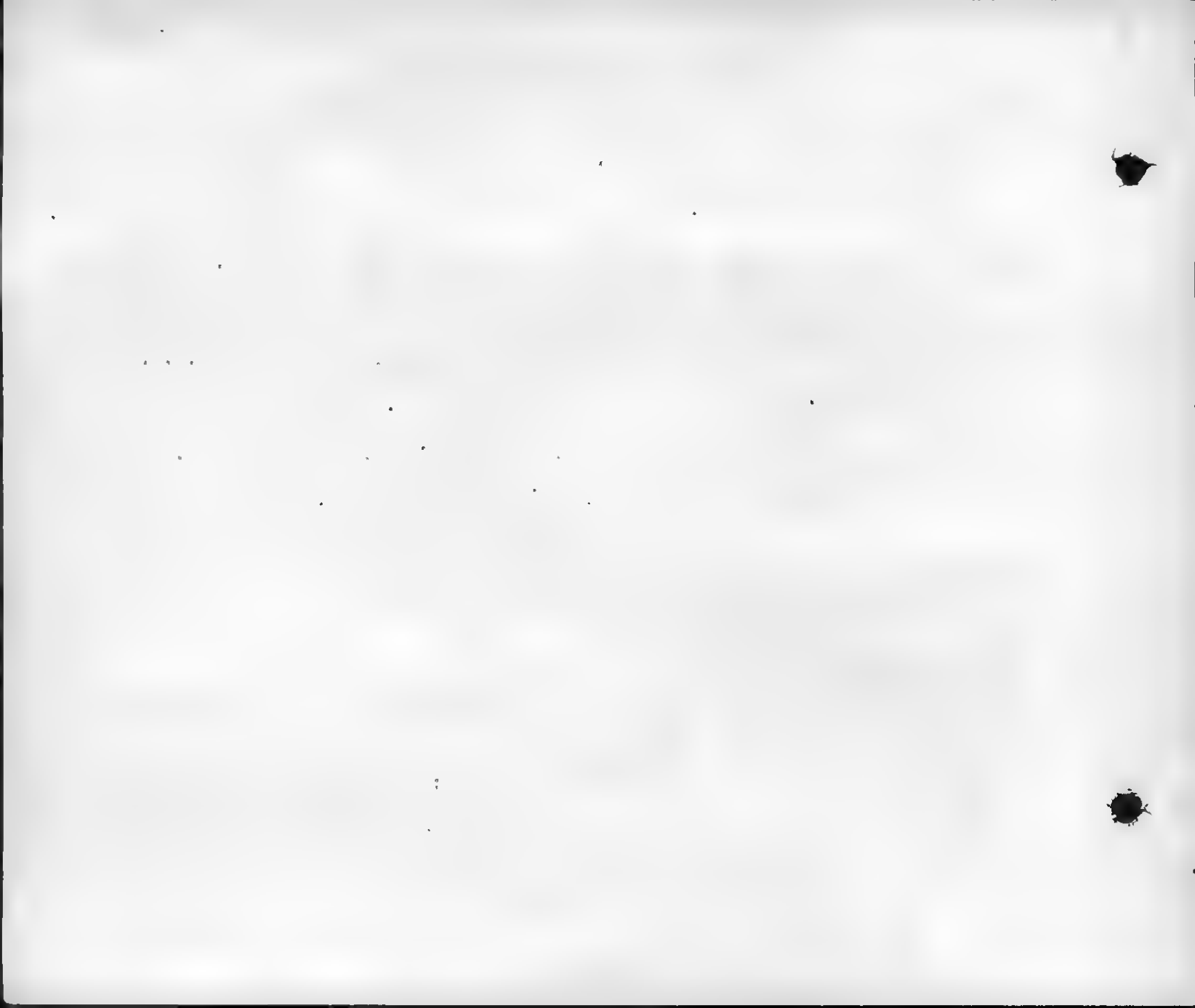
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>9½ HRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give place of death) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. STREET ADDRESS <b>135 HUMBIRD STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>DIANE</b> Middle <b>LYNN</b> Last <b>NEWMAN</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4 1957</b>	
9. AGE (In years last birthday) <b>1 22 MOS</b>		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>3</b> Hours <b>0</b> Min <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13. FATHER'S NAME <b>ROBERT C. NEWMAN</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY A. HENRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septic Enteritis - (Viral)</b> 571- DUE TO <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Toxic Convulsions</b> (c) <b>4 hrs.</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan - 14 1959</b> to <b>Jan - 15 1959</b> , that I last saw the deceased alive on <b>Jan - 14 1959</b> , and that death occurred at <b>1:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>HAROLD ELIASON</b>				ADDRESS (Street, city or town, state) <b>176 E. Main St. Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>HAROLD ELIASON</b>				DATE SIGNED <b>1/16/59</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>(Signature)</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 1-23-59 et

00067

Item 3, Film G238, 1/26/59

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Virginia Ave.</b>		d. STREET ADDRESS <b>124 Virginia Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Paul</b> Last <b>Niewarner</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1882</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Broadway, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Niewarner</b>		14. MOTHER'S MAIDEN NAME <b>E. ma Rinehart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-03-8689</b>	
17. INFORMANT <b>Paul C. Niewarner</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b> DUE TO <b>Carcinoma of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>5-yr</b> <b>18-mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 18, 1959</b> to <b>Jan 19, 1959</b> that I last saw the deceased alive on <b>Jan 18, 1959</b> and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL <b>Clay E. Durrett</b> M.D. <b>236 Va. Ave. Cumberland</b>		DATE SIGNED <b>1/20/59</b>	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett 236 Virginia Ave. Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta, Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Alta, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 2 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. F.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



45

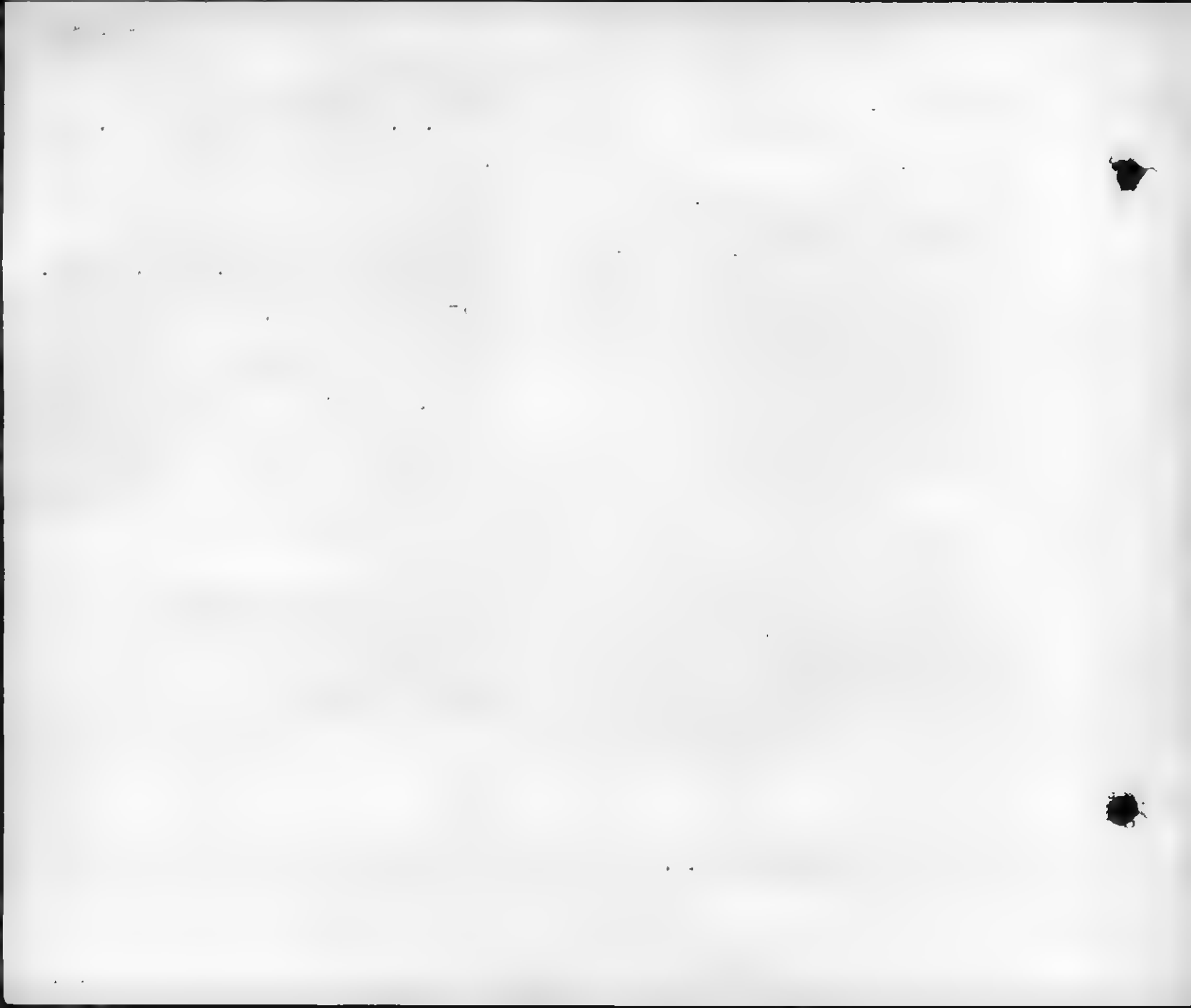
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>W. Va.</b> b. COUNTY <b>Mineral Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wiley Ford</b>	
c. LENGTH OF STAY IN 1b <b>IWk</b>		d. STREET ADDRESS <b>Wiley Ford, W. Va.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Henry</b> First <b>Lee</b> Middle <b>Parrish</b> Last		4. DATE OF DEATH <b>Jan. 16, 1959</b> Month <b>Jan.</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/28, -57</b>
9. AGE (In years last birthday) <b>1yr.</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Maryland</b>	
11 BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Stanley F. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Parrish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Mother</b>		Address <b>Same Address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>acute bronchitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe physical &amp; mental retardation</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1957</b> to <b>January 16, 1959</b> , that I last saw the deceased alive on <b>Jan 16, 1959</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Elizabeth Brings</b> M.D.		PHYSICIAN'S NAME (Type) <b>55 Green Street</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>I-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>W. S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



79

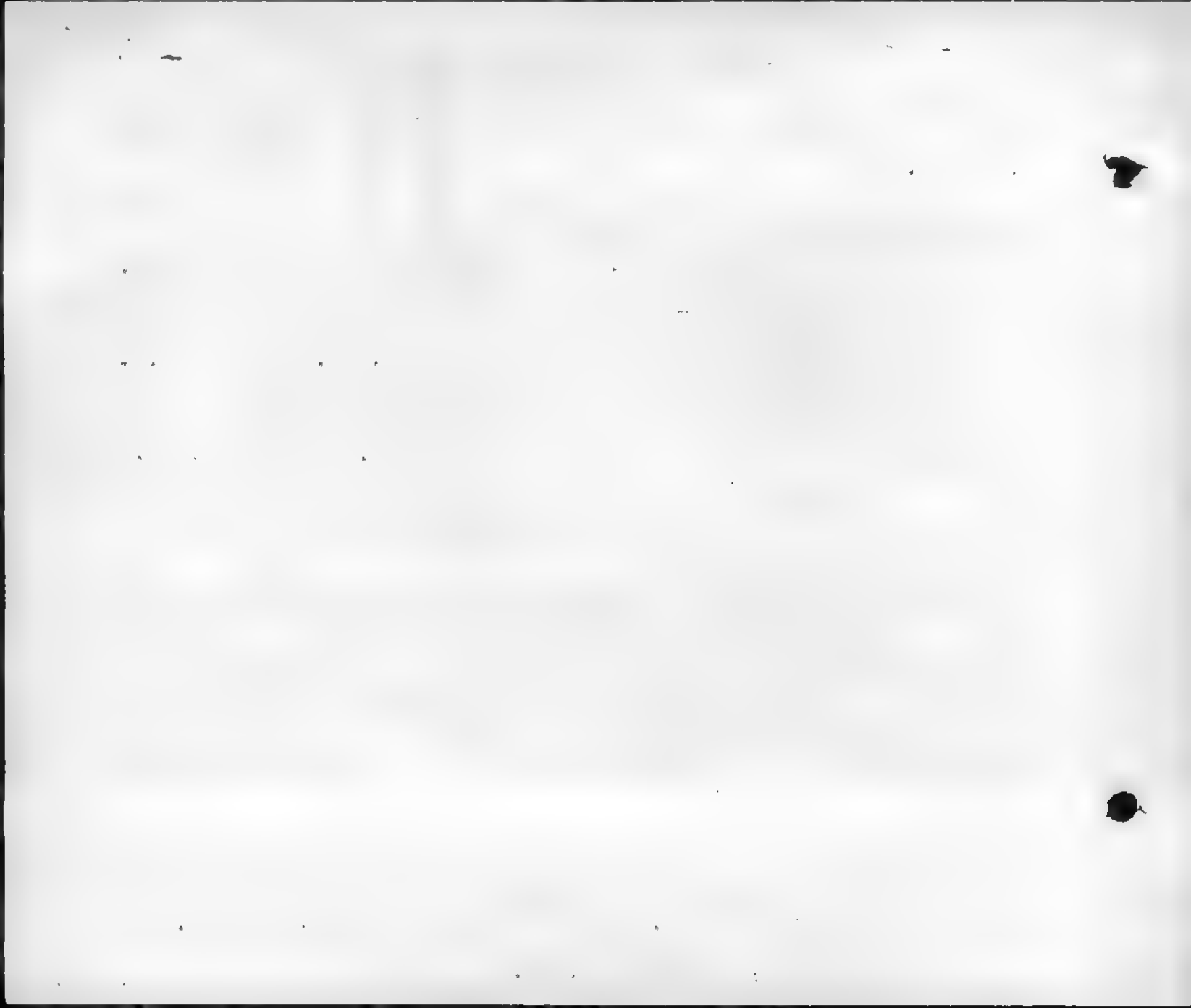
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>F.</b> Last <b>QUINN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/1873</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>10</b> Hours <b>19</b> Mins <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postmaster</b>		11. BIRTHPLACE (State or foreign country) <b>Johnstown, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Quinn</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Murry</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edward Mooney, Lonaconing, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1959</b> Hour <b>o. m.</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 5, 1919</b> to <b>Jan. 19, 1959</b> , that I last saw the deceased alive on <b>Jan. 18, 1959</b> , and that death occurred at <b>6:07 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Miles Jr.</b>		DATE SIGNED <b>1.19.59</b>	
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR.</b>		<b>LONA CONING MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/21/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN, LONA CONING, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00070

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>35 Mill St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Francis</u> Middle <u>D</u> Last <u>Rafferty</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>3</u> Year <u>1959</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov 28 1918</u>		<b>9. AGE</b> (In years last birthday) <u>40</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min _____									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>City streets</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frostburg Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Charles Rafferty</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anastasia Scally</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>yes World War II</u>				<b>16. SOCIAL SECURITY NO</b> <u>714-14-6236</u>		<b>17. INFORMANT</b> <u>Mary A Cairdy</u>		Address <u>Frostburg Md</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death Evidently</u> <u>4344</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to Heart Distillation</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19 _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>															
<b>ACTUAL SIGNATURE</b> <u>LLC McLaure</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>Jan 4 1959</u>							
<b>EXAMINER'S NAME (Type)</b> <u>LLC McLaure</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>1-7-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Arlington Va.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harvey H. Zeigler</u>						<b>ADDRESS</b> <u>Hyndman, Pa.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Chas A S. Thoma</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 236 1-14-9 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

c. LENGTH OF STAY IN 1b

13 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CUMBERLAND Frostburg

d. STREET ADDRESS

131 Maple Street

e. IS RESIDENCE  
ON A FARM  
YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MEMORIAL HOSPITAL  
MEMORIAL & WARWICK AVES.3. NAME OF  
DECEASED  
(Type or print)

Emma

V.

Raley

4. DATE  
OF  
DEATH

Jan.

7

19 59

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

MARCH 11

9. AGE (In years  
last birthday)

82 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days Hours M n

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House work

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM SHERMAN

14. MOTHER'S MAIDEN NAME

ANN MOWRY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Lobar Pneumonia, right

440X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture of Left femur

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Fell at County Home (Sylvan Retreat)

20c. TIME OF INJURY

Month, Day, Year

6:30 a.m.

Dec. 24 1958

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

County Home

20f. (City or town)

Cumberland, alleg. Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL  
SIGNATURE

Benedict Skitarelic

-M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Jan. 8, 1959

22a. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

1-11-59

22c. NAME OF CEMETERY OR CREMATORY

Hyndman Cemetery

22d. LOCATION (City, town, or county)

Hyndman, Pa.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

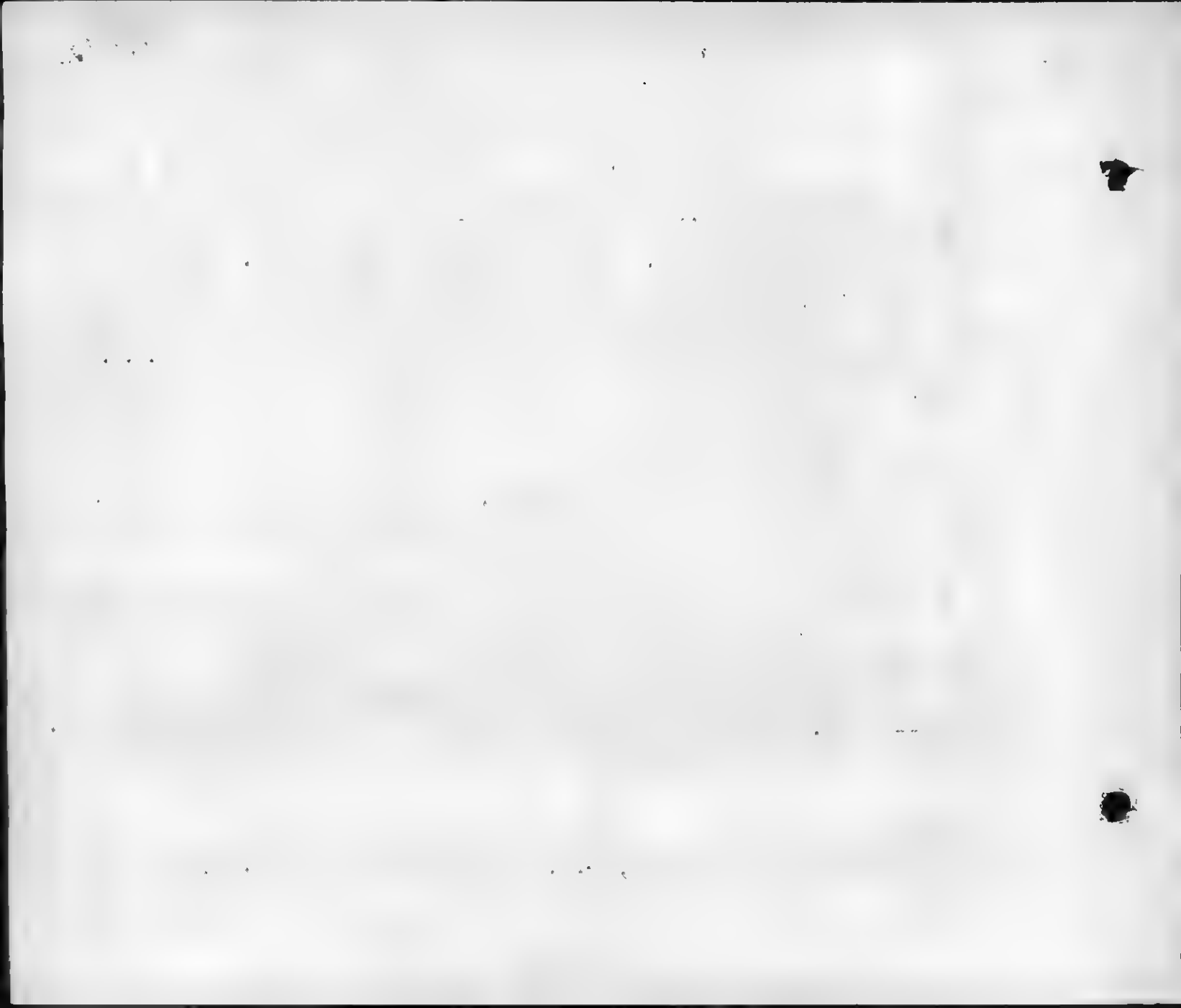
Hyndman, Pa.

24a. REC'D BY REGISTRAR

JAN 12 1959

24b. REGISTRAR'S SIGNATURE

S. K. K.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

98

## CERTIFICATE OF DEATH

00072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Route 4, Willowbrook Road</b> <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 4, Willowbrook Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOVELL LEO REYNOLDS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Craig County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Floyd Addison Reynolds</b>		14. MOTHER'S MAIDEN NAME <b>Emma Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Rt. 4, Willowbrook Road</b>	
17. INFORMANT <b>Mrs. Ella Reynolds</b>		<b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause only for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/22/57</b> , 19___, to <b>1/10/59</b> , 19___, that I last saw the deceased alive on <b>1/10/59</b> , 19___, and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 So. Centre St. Cumberland, Md.</b> DATE SIGNED <b>Jan 13 1959</b>			
ACTUAL SIGNATURE <b>Richard J. Williams</b> M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>Jan. 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hills Mem. Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24c. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



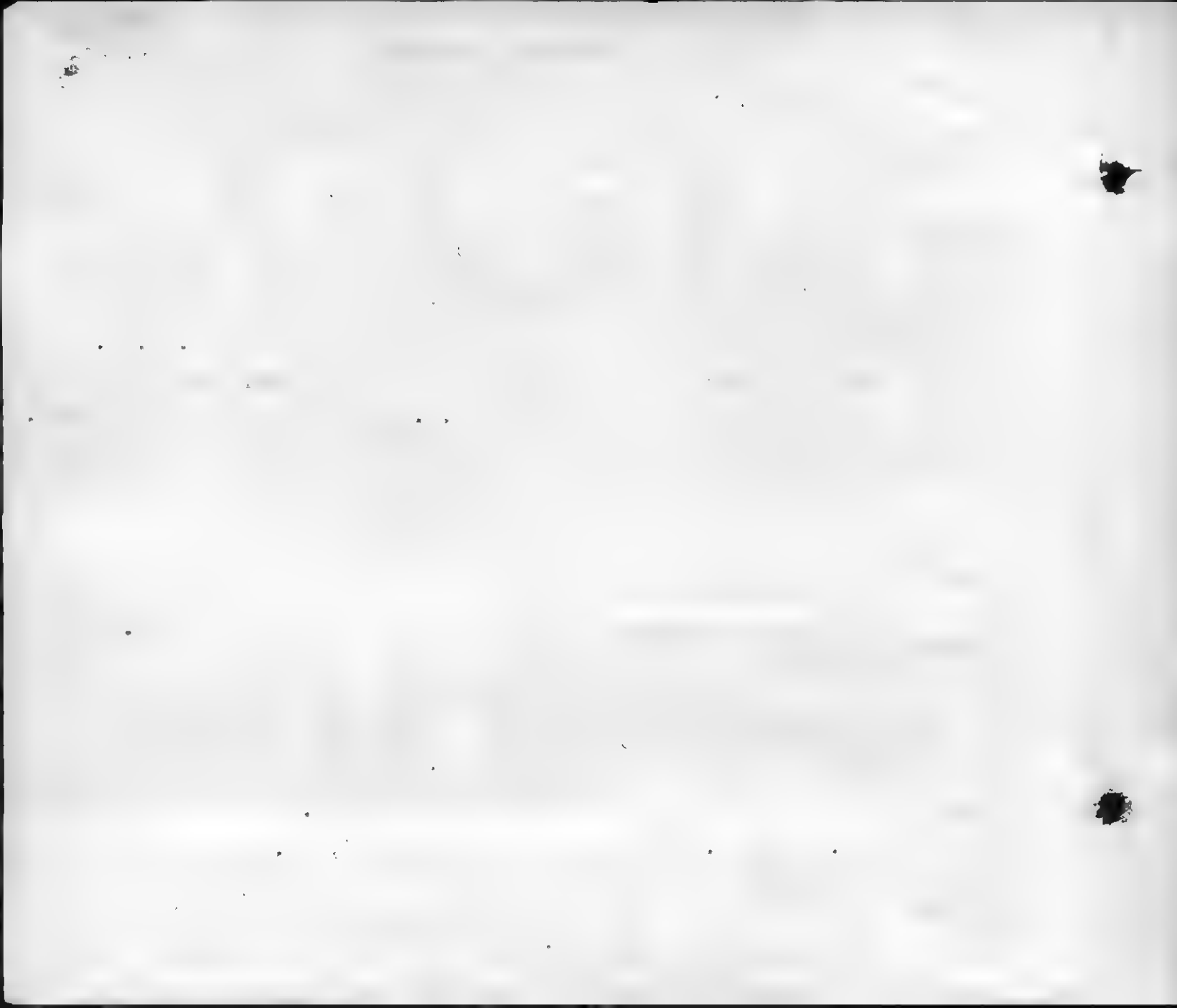
## 47 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/3/54</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
f. STREET ADDRESS <b>517 Eastern Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amy</b> Middle <b>Rice</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/1874</b>
9. AGE (In years last birthday) <b>84</b> yrs		IF UNDER 1 YEAR: Months <b>8</b> Days <b>4</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Brant</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Oyster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity &amp; Senile psychosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/3/54</b> 19 to <b>1/8/59</b> 19, that I last saw the deceased alive on <b>1/7/59</b> 19, and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>49 Greene St.</b>		DATE SIGNED <b>1/8/59</b>	
ACTUAL SIGNATURE <b>Dr. James E. McLean</b>		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/10/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Frazier</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

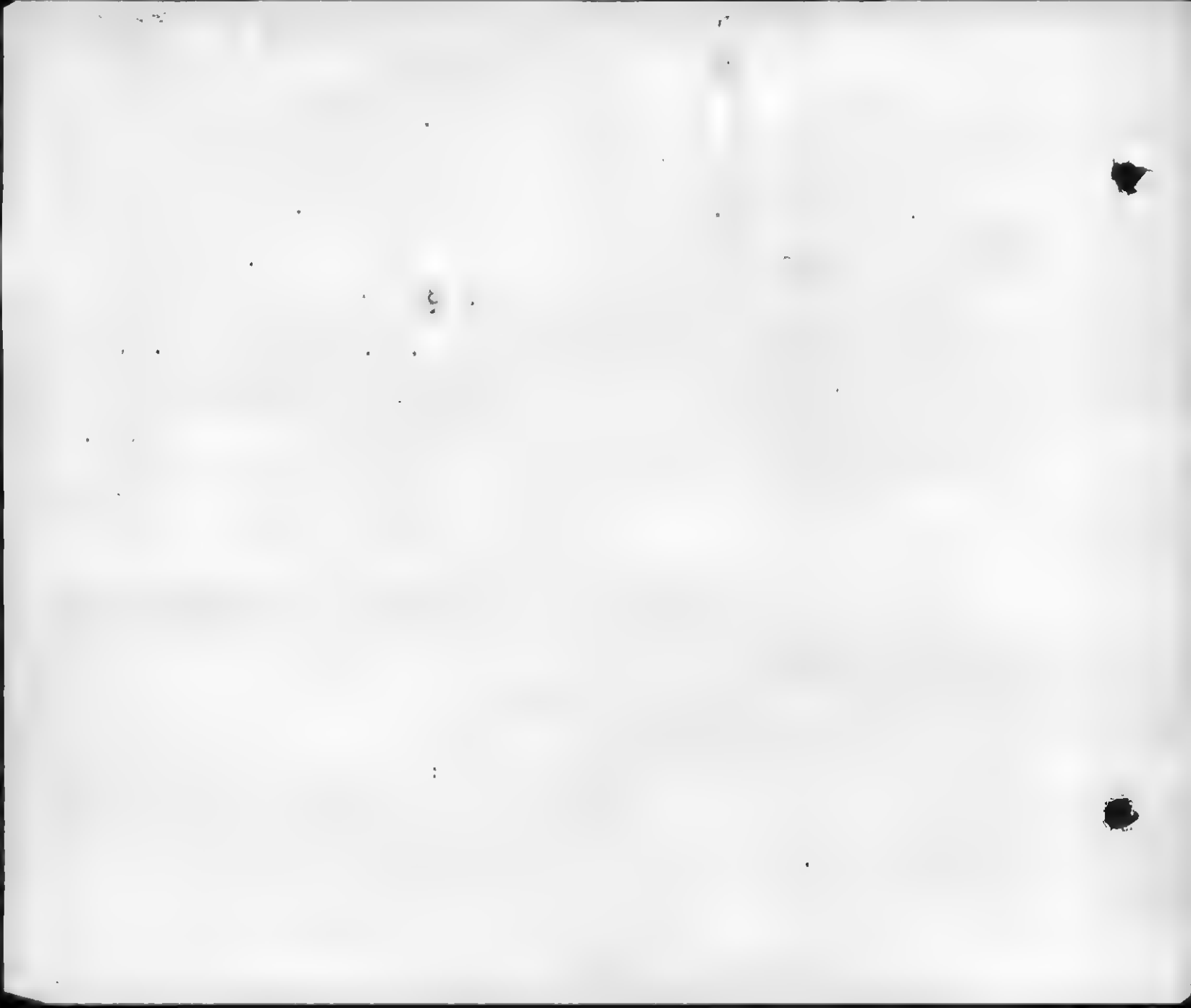
# Item 7 Filed 1959-2-24 et 48 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## CERTIFICATE OF DEATH

00074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss on) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>26 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>317 GRAND AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>JESSE JAMES ROACH</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 18, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>	11. IF UNDER 24 HRS Hours <b></b> M n <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA. Hardy Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES ROACH</b>		14. MOTHER'S MAIDEN NAME <b>MAKKIE Maggie Shoemaker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Trauma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; Decomposition</b> DUE TO (c) <b>Antemortem</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 min</b> <b>5 min</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 29</b> , 19 <b>58</b> , to <b>Jan 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 29</b> , 19 <b>59</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay Durrett</b> M.D. <b>Cumberland Md</b>		DATE SIGNED <b>1/30/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>Feb. 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>McGaheysville Cemetery</b>		<b>McGaheysville, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lindsey's Sons</b>		ADDRESS <b>Harrisonburg, Va</b>	
24a. REC'D BY REGISTRAR <b>FEB 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cuthbert L. Hume</b>	



49

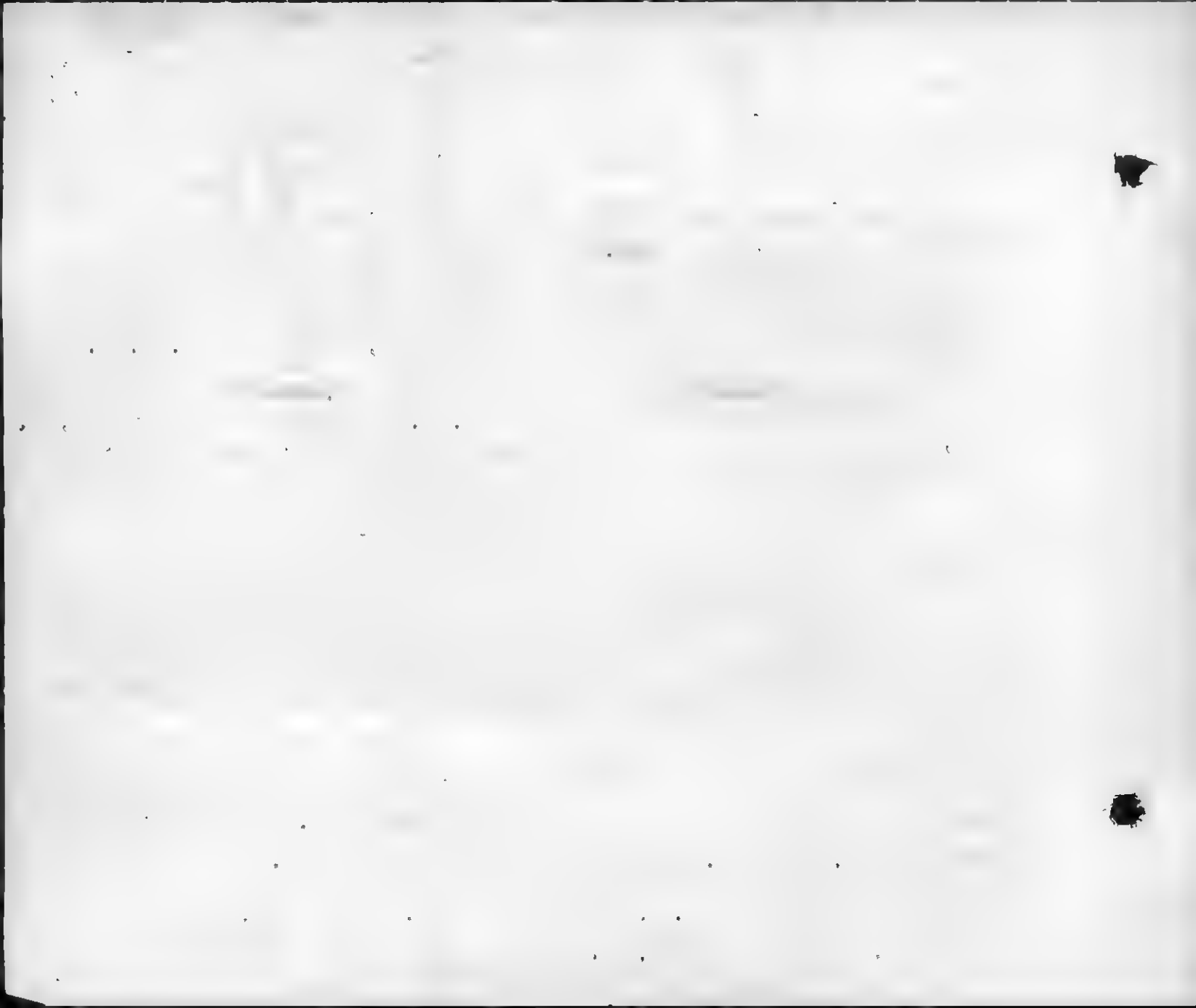
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>2/12/54</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>	
e. STREET ADDRESS <b>Bedford Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Mary</b> Last <b>Ruppert</b>		4 DATE OF DEATH Month <b>January</b> Day <b>28</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/1873</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Brockman</b>		14. MOTHER'S MAIDEN NAME <b>Bernadine Landwehr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P. O. Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Chronic Osteoarthritis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe deterioration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/12/54</b> , 19 <b>54</b> , to <b>1/28/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/28/59</b> , 19 <b>59</b> , and that death occurred at <b>6:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>1/29/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



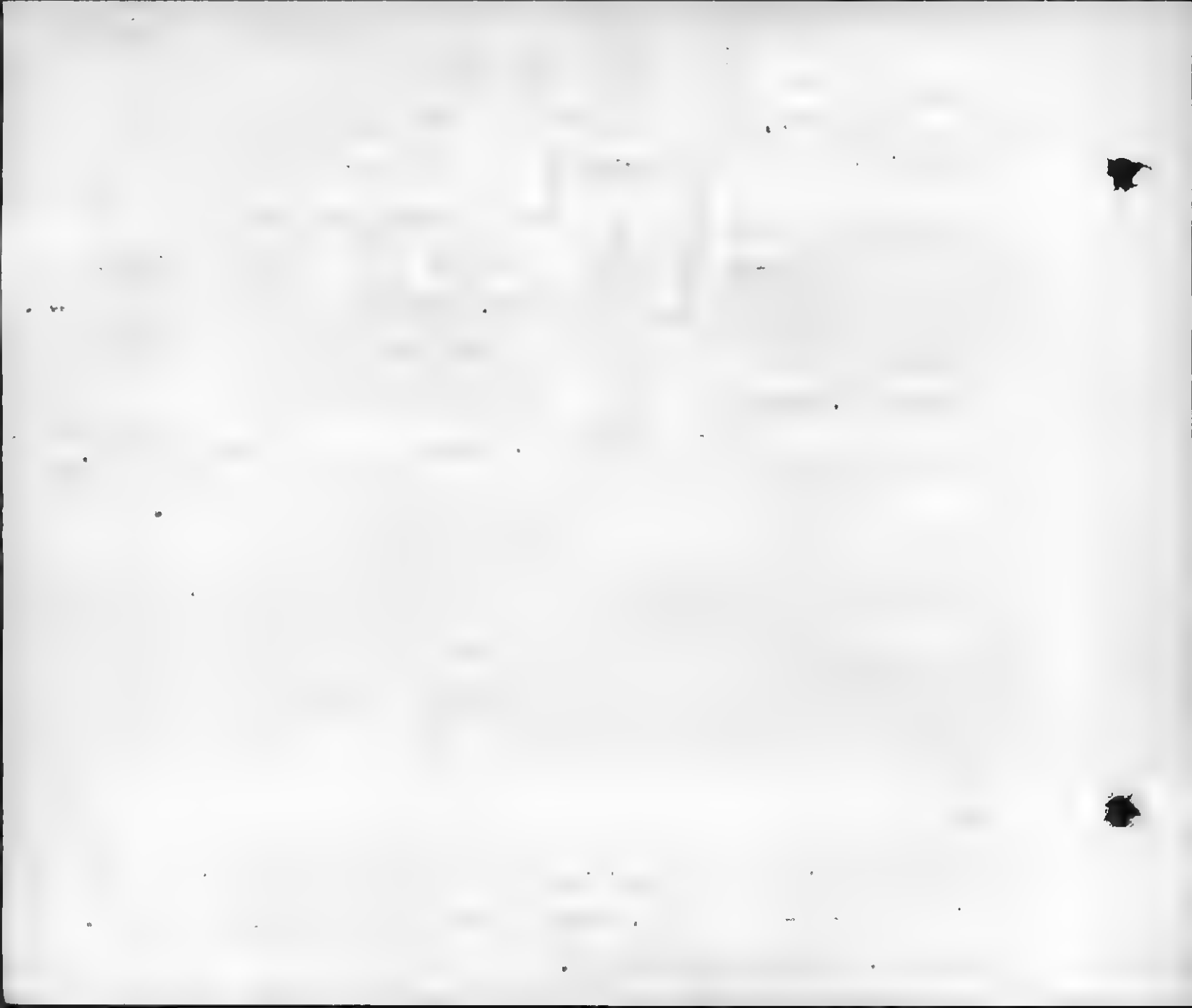
## 81 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY IN 1b <b>Lifetime</b>		2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>42 Wright Street</b>	
3. NAME OF DECEASED (Type or print) <b>George</b> First Middle Last <b>Savage</b>		4. DATE OF DEATH <b>January 19th, 19 59</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15th, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultryman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>George M. Savage</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>213-09-6517</b>	
17. INFORMANT <b>Mrs. Margaret Savage, Frostburg, Md.</b> Address <b>65 Wright St.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Acute Coronary Occlusion</b> <b>440.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive and Arteriosclerotic Heart Disease, with Cardiomegaly, Coronary Insufficiency, and prior (April 1958) Myocardial Infarction.</b> (c) <b>440.1</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 21, 1958</b> , to <b>January 19, 19 59</b> , that I last saw the deceased alive on <b>December 1st, 19 58</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Algonquin Hotel,</b> DATE SIGNED <b>Wyand F. Doerner, Jr., M.D.</b>			
ACTUAL SIGNATURE <b>Wyand F. Doerner, Jr., M.D.</b>		Cumberland, Maryland.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph A. Durst, Frostburg, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. L. Kraw</b>

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



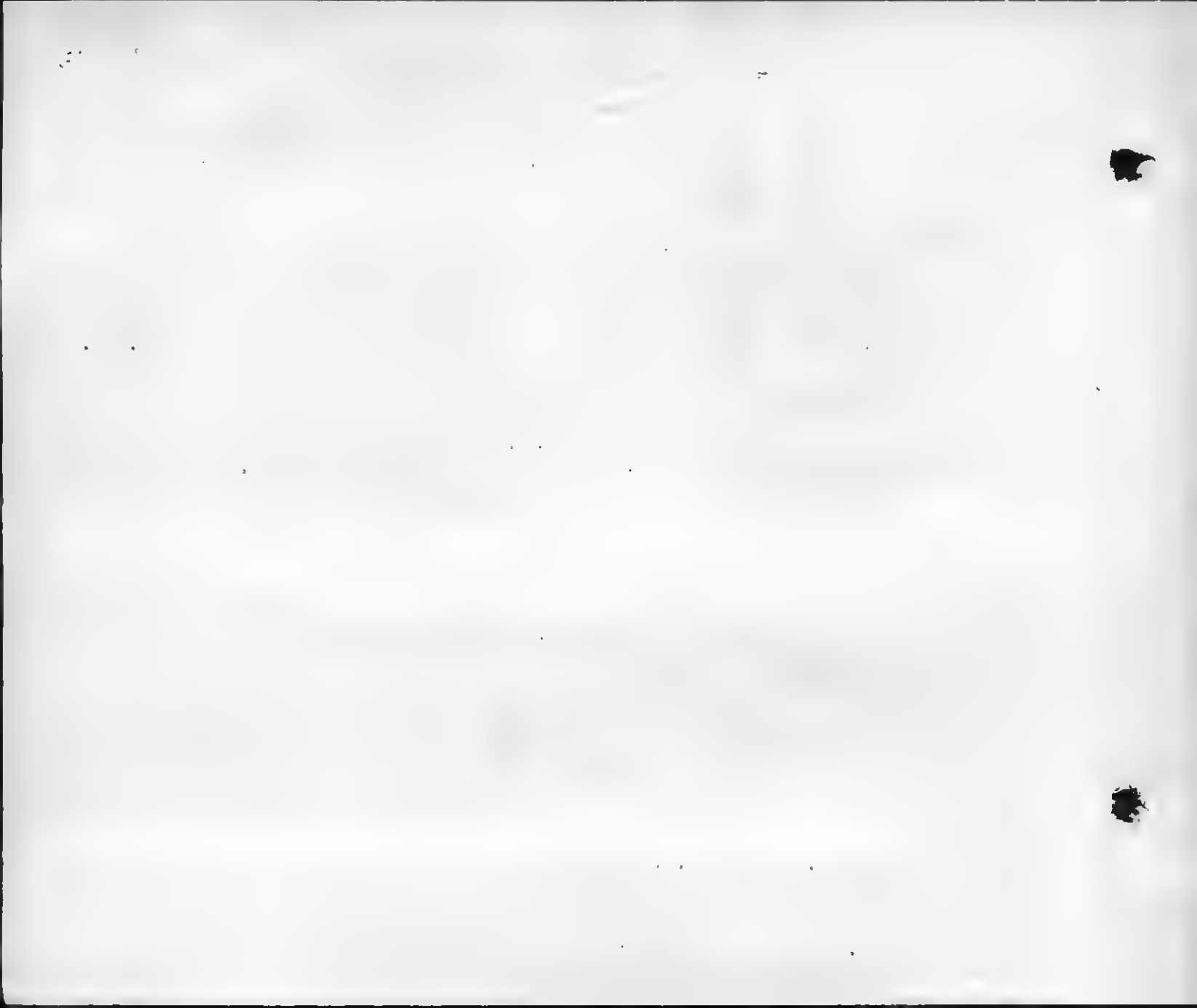
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2yrs; 11mo; 29das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Euphemia</b> Middle <b>Schaub</b> Last <b>Schaub</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/66</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR Months <b>92</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scotland</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Janet Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Janet Martin, 4201 Monoyunk Ave., Phila., Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 Pulmonary Hypertension</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>422 Myocardial Degeneration</b> DUE TO (c) <b>592 Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>?</b> <b>&gt;</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>306 Psychosis with General Ataxo-chorea</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 6th 1956</b> to <b>Jan. 4th 1959</b> , that I last saw the deceased alive on <b>Jan. 3rd 1959</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b> DATE SIGNED <b>1-5-59</b>			
ACTUAL SIGNATURE <b>James E. McLean M.D.</b>			
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D., 49 Greene St., Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. McMonial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.





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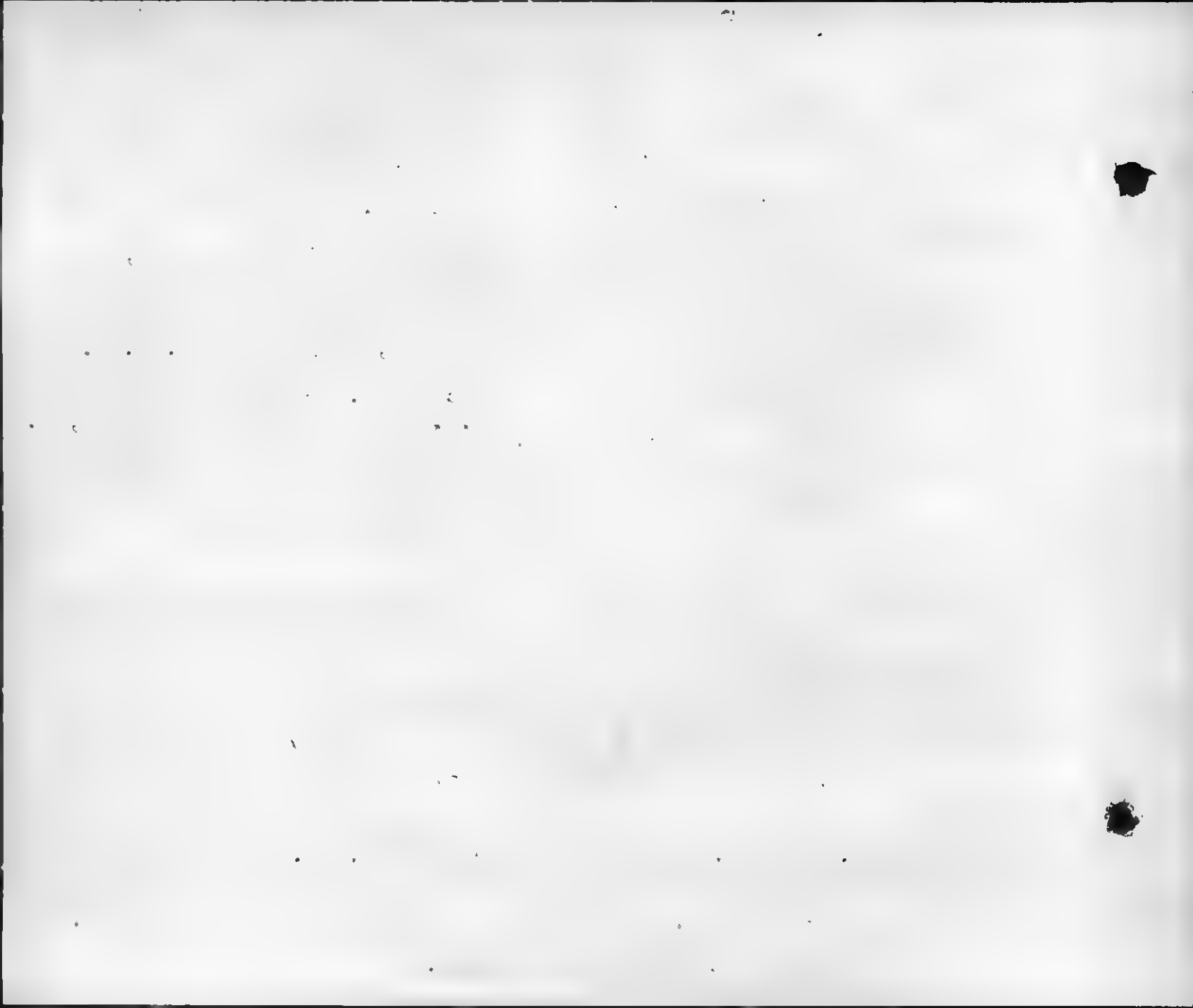
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY IN 1b <b>12/1/58</b>		d. STREET ADDRESS <b>200 E. Main Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Frances</b> Last <b>Shappee</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/21/1876</b>
9. AGE (In years last birthday) yrs <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Powers</b>		14. MOTHER'S MAIDEN NAME <b>Rachael P. Arnold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>277-10-6840</b>	
17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>Arterial Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) <b>Chronic Valvular Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>12/1/1958</b> to <b>1/12/1959</b> , that I last saw the deceased alive on <b>1/10/1959</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene Street</b> DATE SIGNED <b>1/12/59</b>	
ACTUAL SIGNATURE <b>James E. McLean</b>		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Catholic Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Monteant</b>		24a. REC'D BY REGISTRAR <b>JAN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9/17/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>305 Decatur Street, Cumberland</b>	
		d. STREET ADDRESS <b>305 Decatur St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Matilda</b> Last <b>Sharp</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/1885</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William A. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Beamer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P. O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary sclerosis, -</b> 4 days DUE TO (b) <b>Chronic myocardial degeneration ?</b> DUE TO (c) <b>Cerebral arteriosclerosis ?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephritis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/17/58</b> , 19____, to <b>1/27/59</b> , 19____, that I last saw the deceased alive on <b>1/26/59</b> , 19____, and that death occurred at <b>5:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean M.D.</b>		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>1-27-59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Enola Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Enola Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Stein Inc</b>		ADDRESS <b>Cumb. Md</b>	
24a. REC'D BY REGISTRAR <b>JAN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John P. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



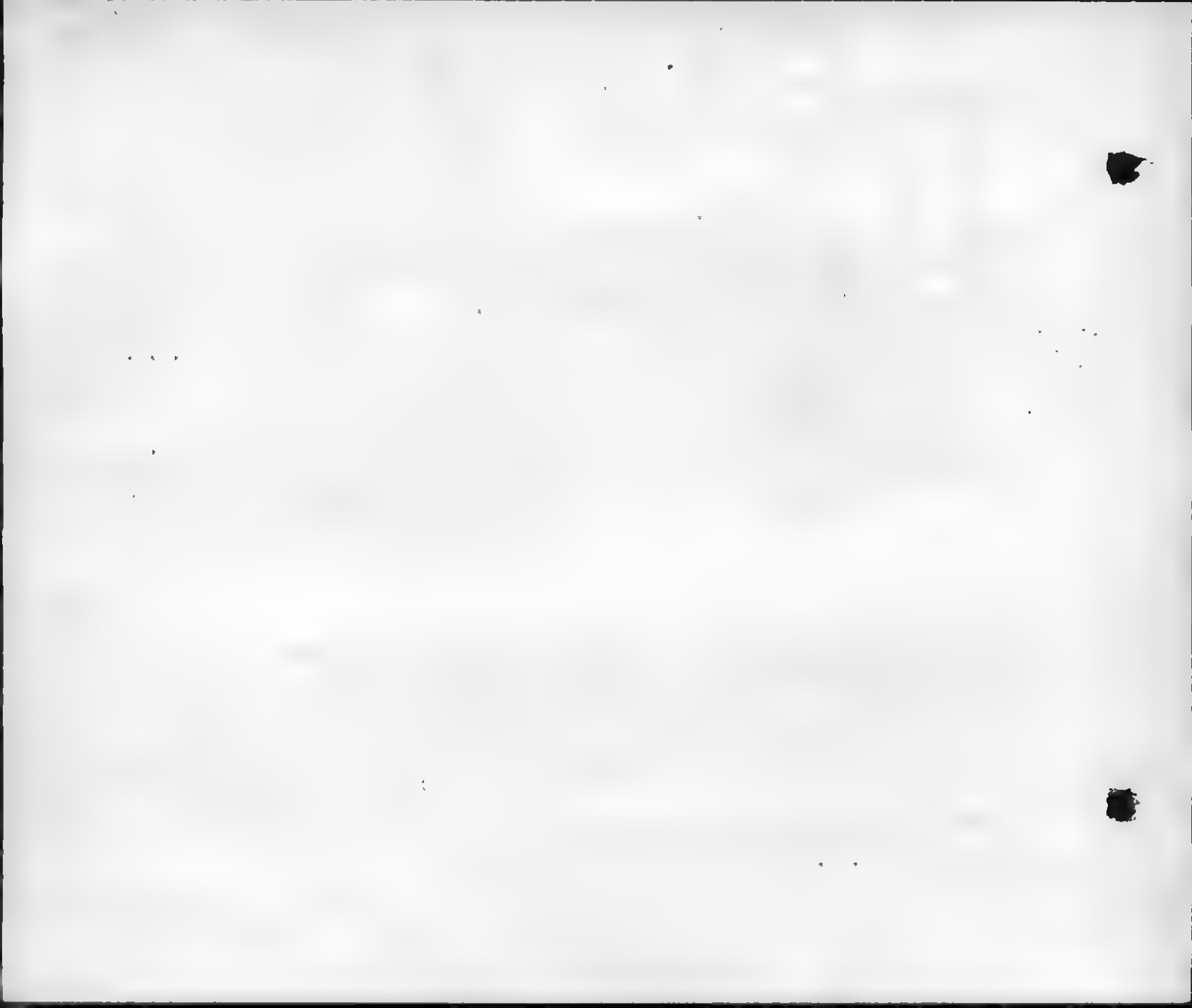
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00080

## 53 . CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>46 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCINDA</b> Middle <b>SHATZER</b> Last <b>SHATZER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 6</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>19</b> Hours <b>59</b> Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Corriganville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL GAREY</b>		14. MOTHER'S MAIDEN NAME <b>LUCINDA HINER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, recurrent</b> DUE TO <b>Recent episode Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive and arteriosclerotic Vascular disease</b> DUE TO <b>15 years +</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 Nov. 58</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4020 Inter-trochanteric Fracture rt. Femur</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Patient slipped off wheel chair</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>16 Mar 58</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11</b> p. m. <b>16 Mar 1958</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland Allegany Md.</b>	
21. I certify that I attended the deceased from <b>12 Jan</b> , 1957, to <b>18 Jan</b> , 1959, that I last saw the deceased alive on <b>18 Jan</b> , 1959, and that death occurred at <b>11:00 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		ADDRESS (Street, city or town, state) <b>122 S. Centre St. Cumberland Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. A. VAN ORMER</b>		DATE SIGNED <b>18 Jan 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR <b>Jan 6 1959</b>		24b. REGISTRAR'S SIGNATURE <b>John P. K...</b>	



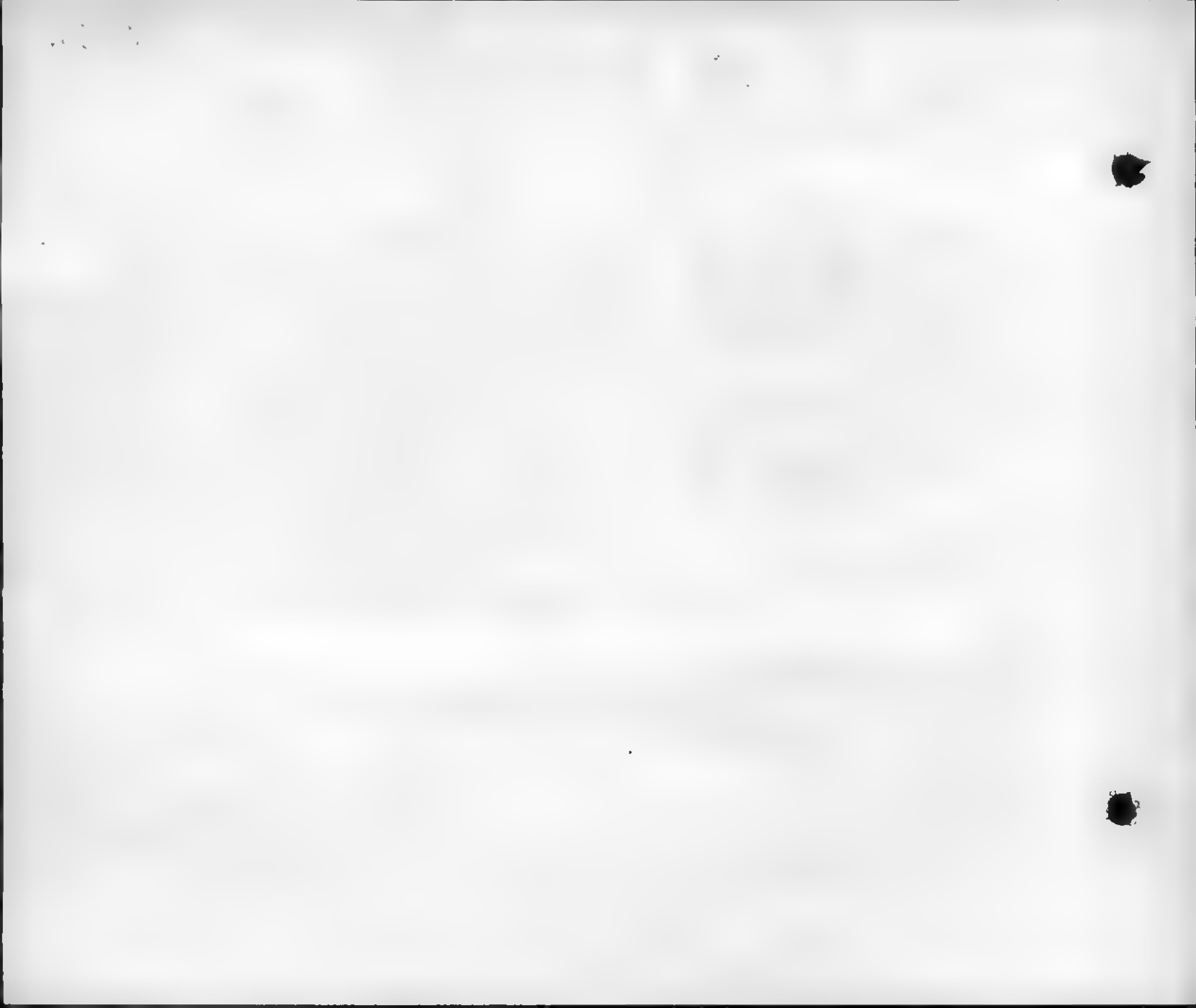
## 99 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown, Md.</b>		c. LENGTH OF STAY IN 1b <b>60yrs</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown, Md.</b>		d. STREET ADDRESS <b>Oldtown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <b>James H. Shaw</b>		4. DATE OF DEATH Month Day Year <b>Janusry 12, 19 59</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 2, 1875</b>		9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Tie Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Charles E. Shaw</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Taylor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-10-5551</b>													
17. INFORMANT Address <b>B Clarence Shaw Oldtown Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Dracemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO <b>Disease</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>15 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11/12/1959</b> , 19 <b>1959</b> , that I last saw the deceased alive on <b>11/12/1959</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>236 Va. Ave. Cumberland Md.</b>		DATE SIGNED <b>7/12/59</b>		ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D. <b>Clay E. Durrett</b>		PHYSICIAN'S NAME (Type) <b>Clay E. Durrett 236 Virginia Ave. Cumberland, Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>I- 15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Oldtown, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Durrett</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





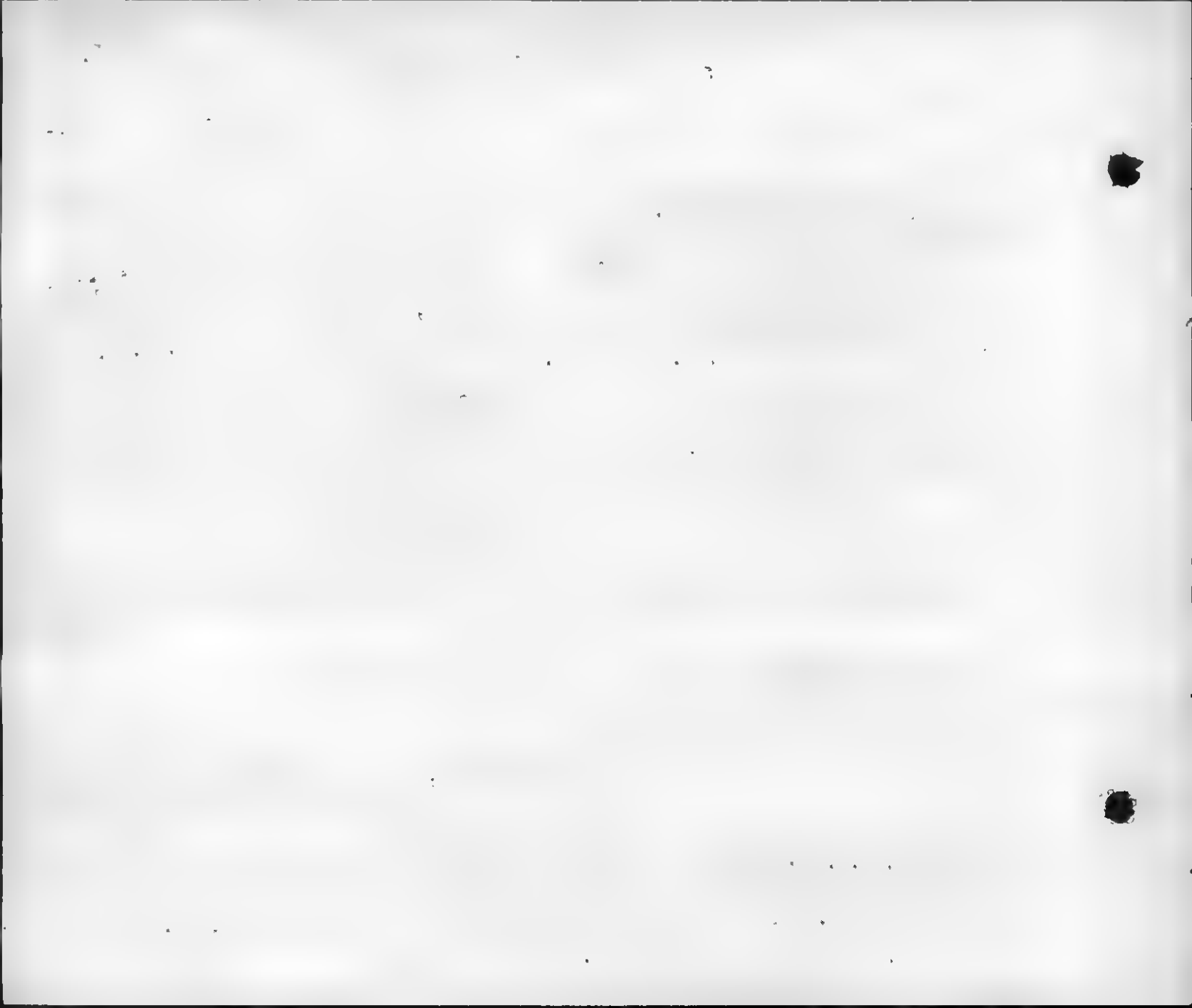
## 54 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>45 MINUTES</b>	
d. NAME OF HOSPITAL (If not in hospital, write name of place where death occurred) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
f. NAME OF HOSPITAL (If not in hospital, write name of place where death occurred) <b>MEMORIAL HOSPITAL</b>		g. STREET ADDRESS <b>509 FAYETTE STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BLAINE CHESTER SHEIRER</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 14 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 2, 1918</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>T. V. Supply Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM SHEIRER</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE STUBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>210-05-3327</b>	
17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-14-1959</b> to <b>1-14-1959</b> , that I last saw the deceased alive on <b>1-14-1959</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. F. Williams</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. F. RICHARD WILLIAMS</b>		DATE SIGNED <b>1-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George,</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>Jan 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Kears</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



55

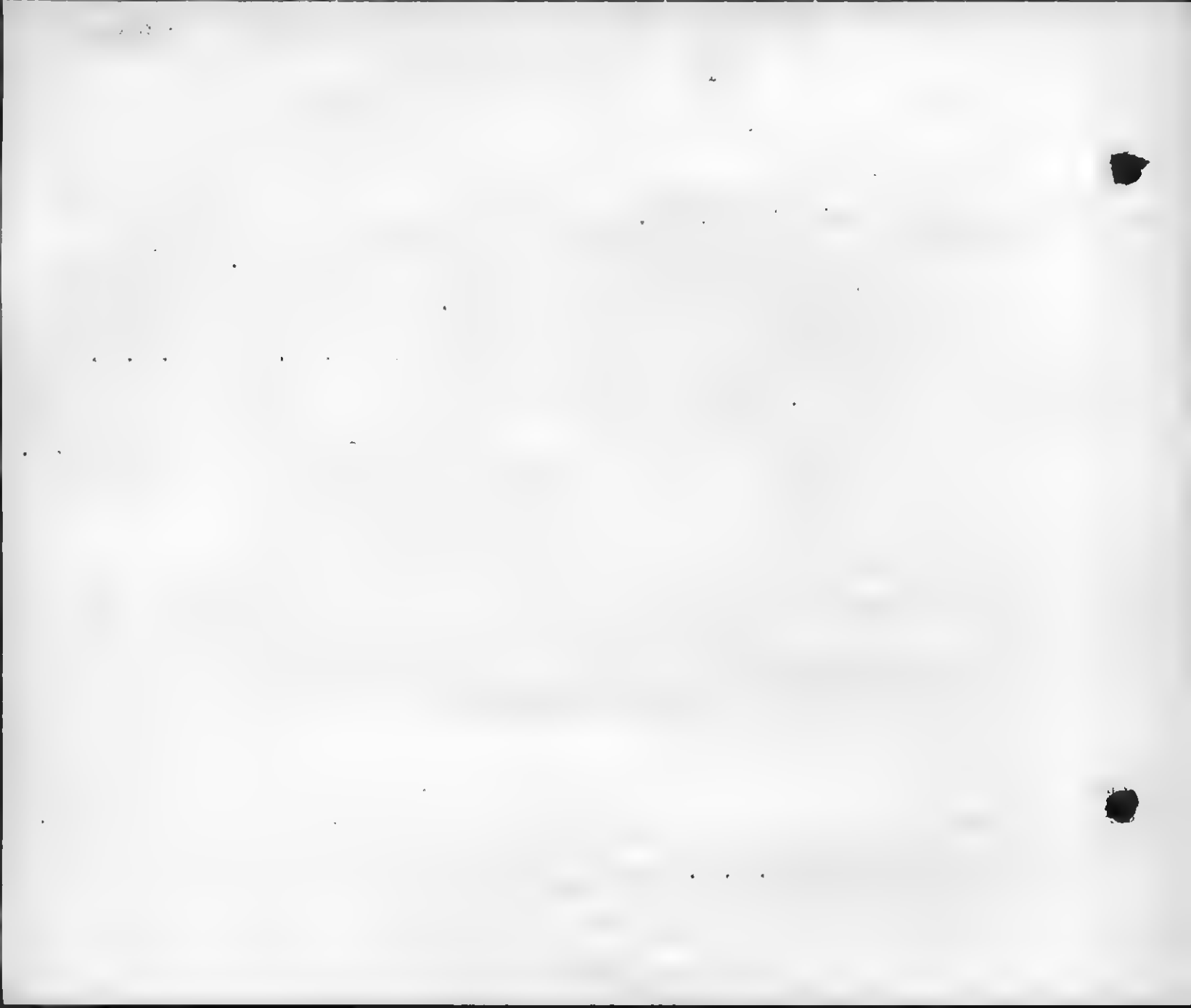
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>BERTHA</b> Last <b>SHUMAKER</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 6</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HIRAM B. WOLFE</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE HITE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X carcinoma of breast with generalized metastases.</b> DUE TO (b) <b>metastases.</b> DUE TO (c) <b>breast</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 20, 1958</b> to <b>January 10, 1959</b> , that I last saw the deceased alive on <b>July 9, 1959</b> , and that death occurred at <b>7:05 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>43 Emerald Cumberland Md</b> DATE SIGNED <b>1/11/59</b>			
ACTUAL SIGNATURE <b>B. M. Schindler M.D.</b>		PHYSICIAN'S NAME (Type) <b>DR. A. J. MIRKIN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Zeigler</b>		ADDRESS <b>Hyndman, Pa.</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 12 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Clara E. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 show to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

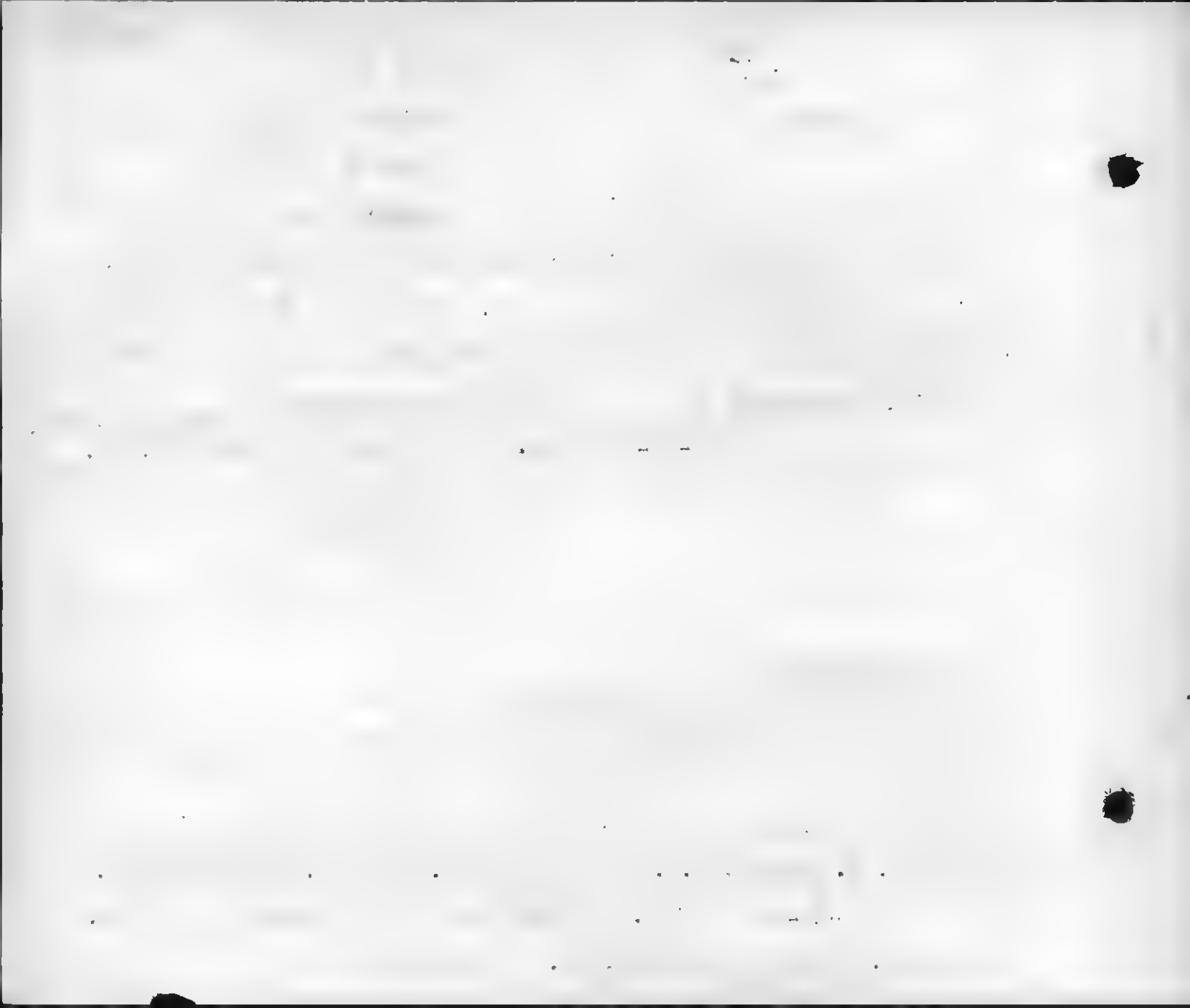


## 82 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frostburg Hospital</b>		d. STREET ADDRESS <b>20 Braddock Road</b>	
3. NAME OF DECEASED (Type or print) <b>Royal Clifton Skidmore</b>		4. DATE OF DEATH <b>January 24<sup>th</sup>, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2nd, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bituminous Coal Operator</b>		10b. KIND OF BUSINESS, OR INDUSTRY <b>Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Clifton Skidmore</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Brode</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-5449</b>	
17. INFORMANT <b>Mrs. Marion Skidmore, Frostburg, Md.</b>		Address <b>20 Braddock Rd.,</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Hypertension</b> DUE TO (b) <b>Cardiac Failure</b> DUE TO (c) <b>Renal Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>Several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1959</b> , to <b>Jan 24, 1959</b> , that I last saw the deceased alive on <b>Jan 24, 1959</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>W. O. McLane</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>Jan 26 1959</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M.D.</b>		<b>167 E. Main St., Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'b'g. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 28 '59</b> 24b. REGISTRAR'S SIGNATURE <b>W. S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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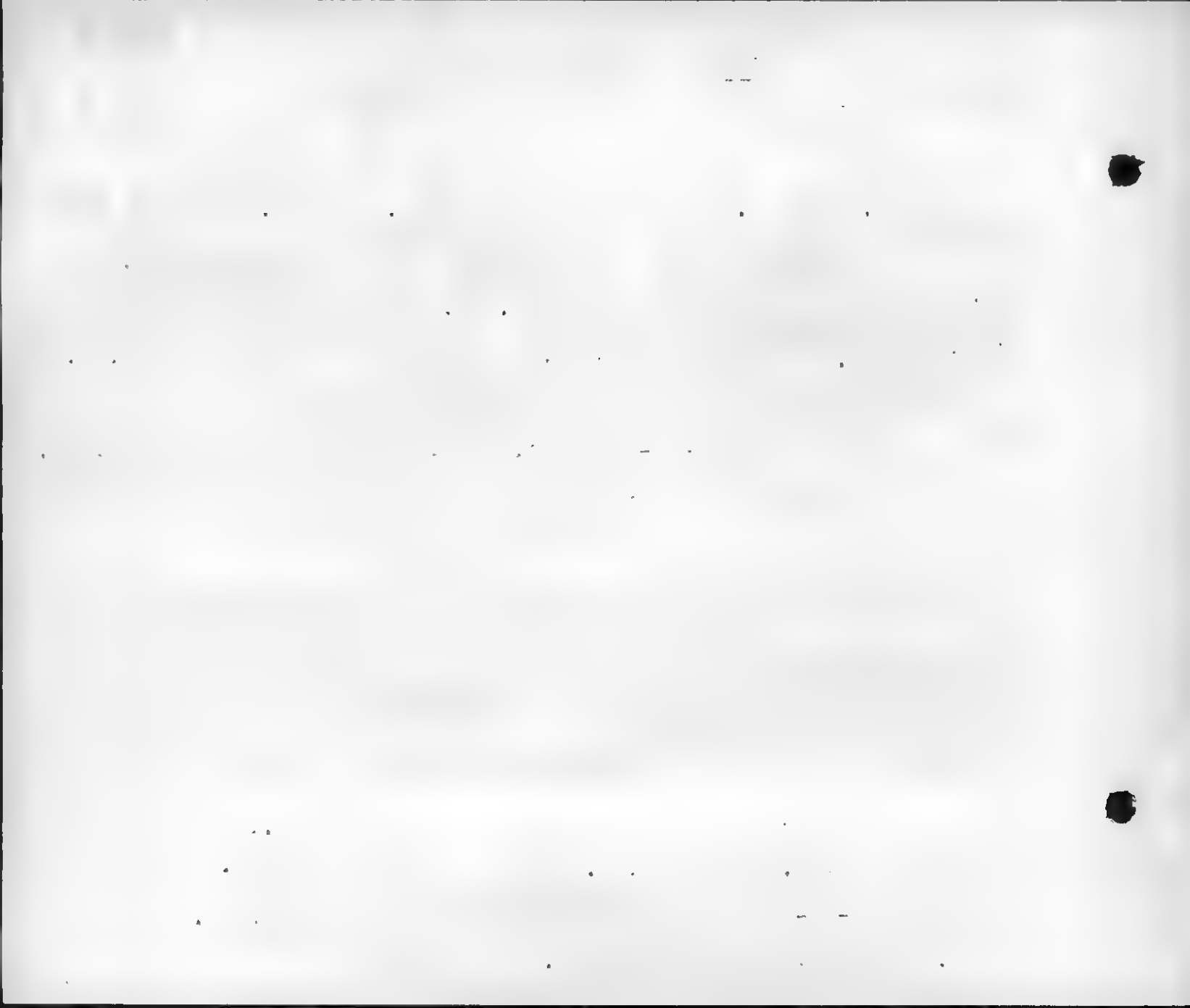
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>56 W. Main St.</b>		d. STREET ADDRESS <b>56 W. Main St.</b>	
3. NAME OF DECEASED (Type or print) <b>LENA</b> First <b>SMITH</b> Middle <b>SMITH</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1910</b>
9. AGE (In years last birthday) <b>48</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator Textile dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elmer Smith</b>		14. MOTHER'S MAIDEN NAME <b>Enona Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>220-10-8551</b>	
17. INFORMANT <b>Mrs. Robt. McLaughlin, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac dilatation</b> DUE TO <b>myocardial insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-4-59</b> to <b>1-23-59</b> , that I last saw the deceased alive on <b>1-23-59</b> , and that death occurred at <b>1-23-59</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. O. McLane</b> M.D.		ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>1-23-59</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>		Frostburg, Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-24-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

56

CERTIFICATE OF DEATH

00086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. STREET ADDRESS <b>Detmold Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/80</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Barkley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Frazier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. James Muir</b> Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331 Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>42c Arteriosclerotic Heart Disease</b> DUE TO (c) <b>45c General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3c4 Female psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 16th, 1958</b> , to <b>JAN. 16th, 1959</b> , that I last saw the deceased alive on <b>JAN. 14th, 1959</b> , and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>1-16-59</b> ACTUAL SIGNATURE <b>James E. McLean</b> M.D. <b>49 Greene St.</b> PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b> <b>49 Greene St., Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 59</b> DATE <b>JAN 20 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. S. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Filed 2-2-59 et

## CERTIFICATE OF DEATH

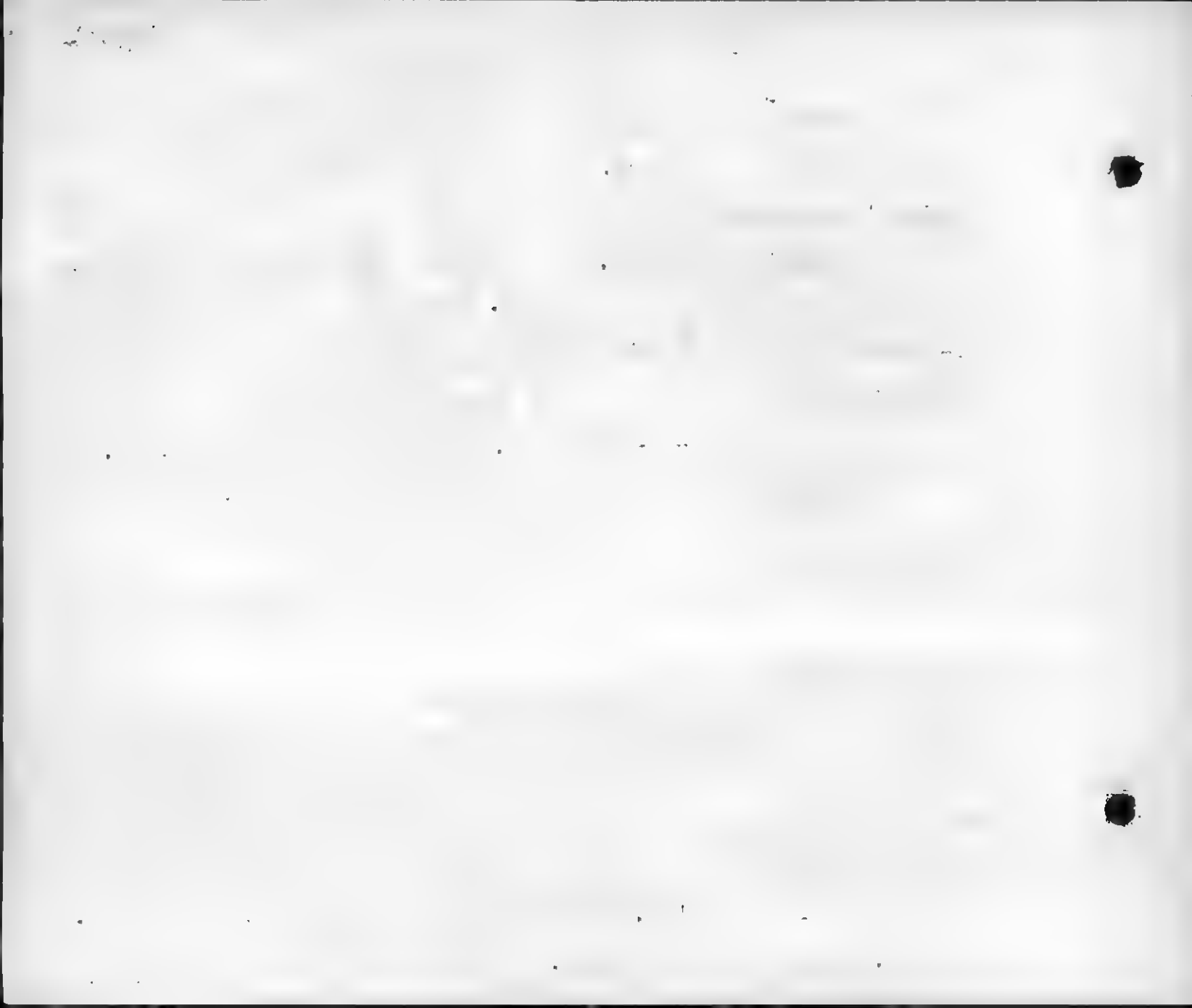
00087

Reg. Dist. No.

84

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>3 Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midlothian</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26th</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27th, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Curing Room</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Springfield</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
13. FATHER'S NAME <b>Benjamin Smith</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Black</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-4986</b>		17. INFORMANT Address <b>Mrs. Pearl Smith, Midlothian, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>443 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>Signal</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1453</b> 19 <b>59</b> , to <b>Jan 26</b> 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 26</b> 19 <b>59</b> , and that death occurred at <b>2:30 p.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William H. Kane</b> M.D. <b>Frostburg</b> PHYSICIAN'S NAME (Type) <b>W. H. Kane</b> <b>711d</b> <b>Jan 26 1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

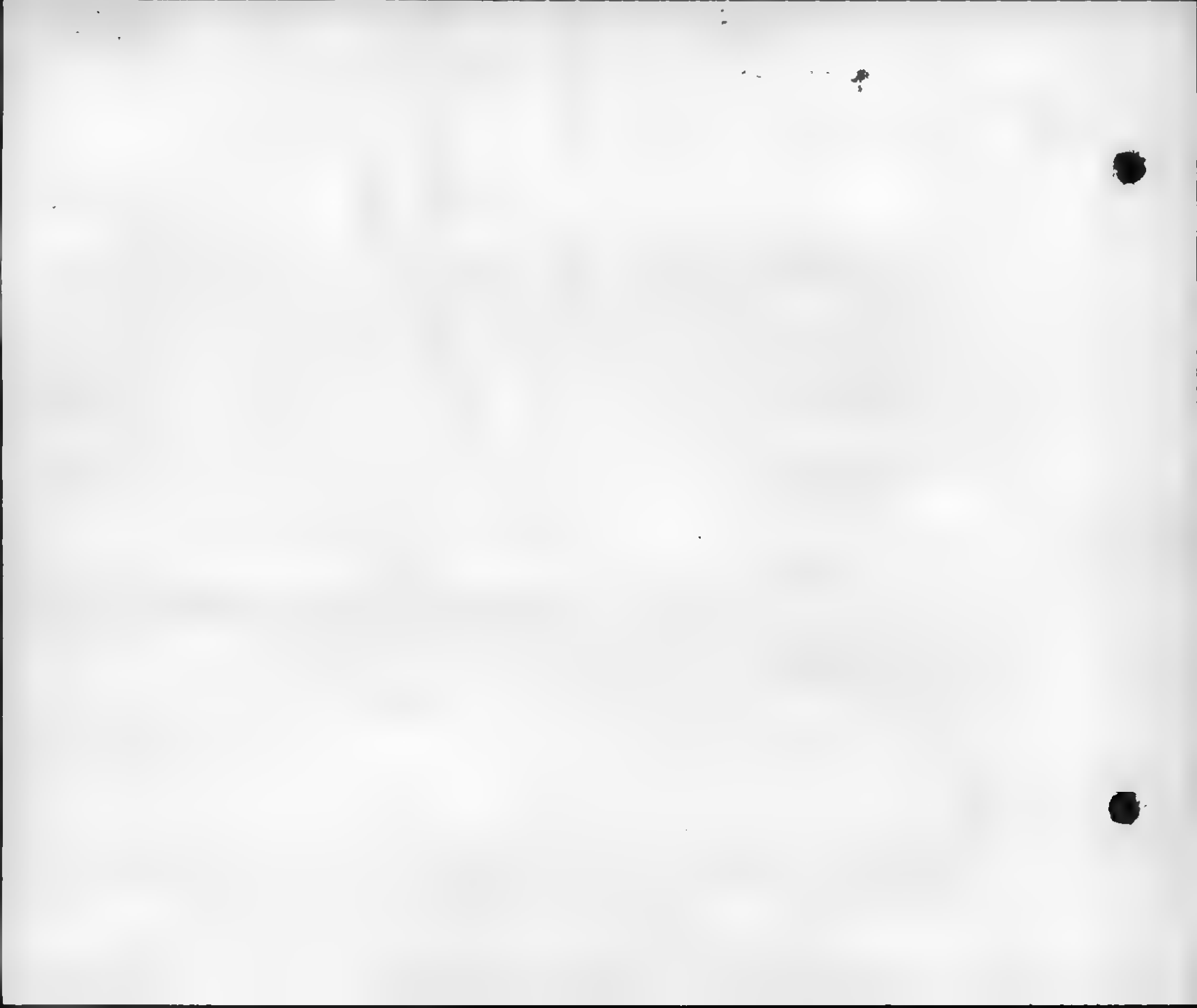


# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dona Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John Wm.</b> Middle <b>Snyder</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>16,</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Cumberland</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>
13. FATHER'S NAME <b>Henry Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Llewellyn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-5632</b>	
17. INFORMANT <b>Bertha Snyder</b>		Address <b>108 Blaul Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO <b>Coronary Artery Disease</b> (c) <b>Coronary Artery Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) (County) (State) <b>None</b>
21. I certify that I attended the deceased from <b>8/12/47</b> , 19 <b>47</b> , to <b>1/16/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/15/59</b> , 19 <b>59</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>1/17/59</b> ACTUAL SIGNATURE <b>Richard J. Williams</b> M.D. PHYSICIAN'S NAME (Type) <b>Richard J. Williams 122 N. Centre St</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 1959</b>	24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00089

58

## CERTIFICATE OF DEATH

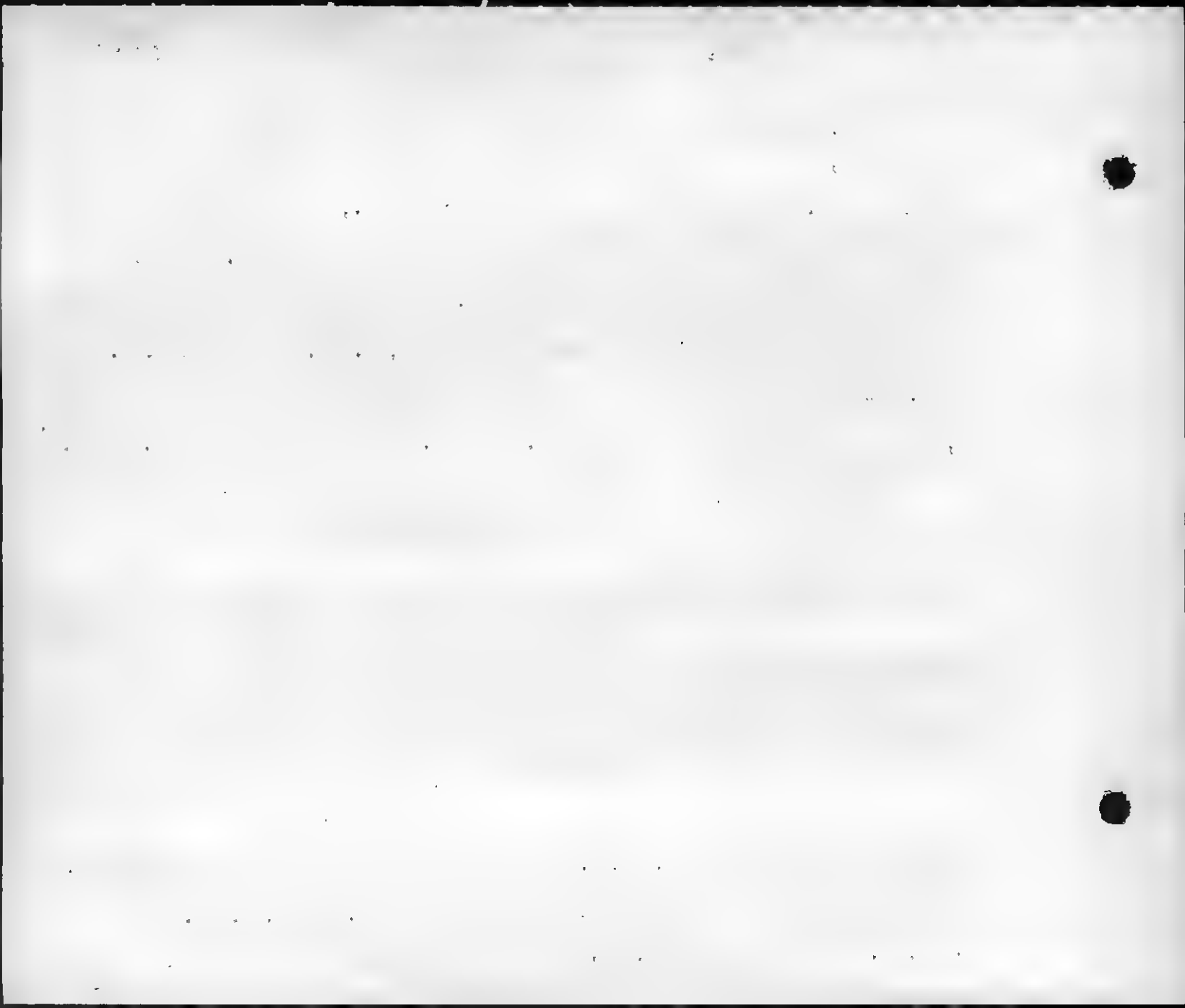
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>INEZ</b> Middle <b>STARKEY</b> Last <b>STARKEY</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pottery Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Clarksburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Greynolds</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ramage</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>Mrs. Sadie E. Triplett 112 Greene St., Cumb.</b>	
17. INFORMANT <b>Mrs. Sadie E. Triplett 112 Greene St., Cumb.</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia (Terminal)</b> <b>1114 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Carcinomatosis</b> DUE TO (c) <b>Carcinoma of Pharynx -</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1st, 1958</b> to <b>Jan 26, 1959</b> , that I last saw the deceased alive on <b>1-26-</b> , 1959, and that death occurred at <b>12:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington St. Cumberland, Md.</b> DATE SIGNED <b>1/26/59</b>			
ACTUAL SIGNATURE <b>Leslie E. Daugherty</b> M.D.		PHYSICIAN'S NAME (Type) <b>Leslie E. Daugherty, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wolf Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Clare, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. L. George</b>			

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

e IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

Day 13 Year 10 50

IF UNDER 1 YEAR		IF UNDER 24 HRS	
Months	Days	Hours	Min

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

DREW WITT

Address  
CUMBERLAND, MARYLAND

INTERVAL BETWEEN ONSET AND DEATH	5 years
-------------------------------------	---------

 $I_{c'}$ 

19 WAS AUTOPS PERFORMED?  
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

(State)

DATE SIGNED \_\_\_\_\_

j-14-54

Cambridge Mass

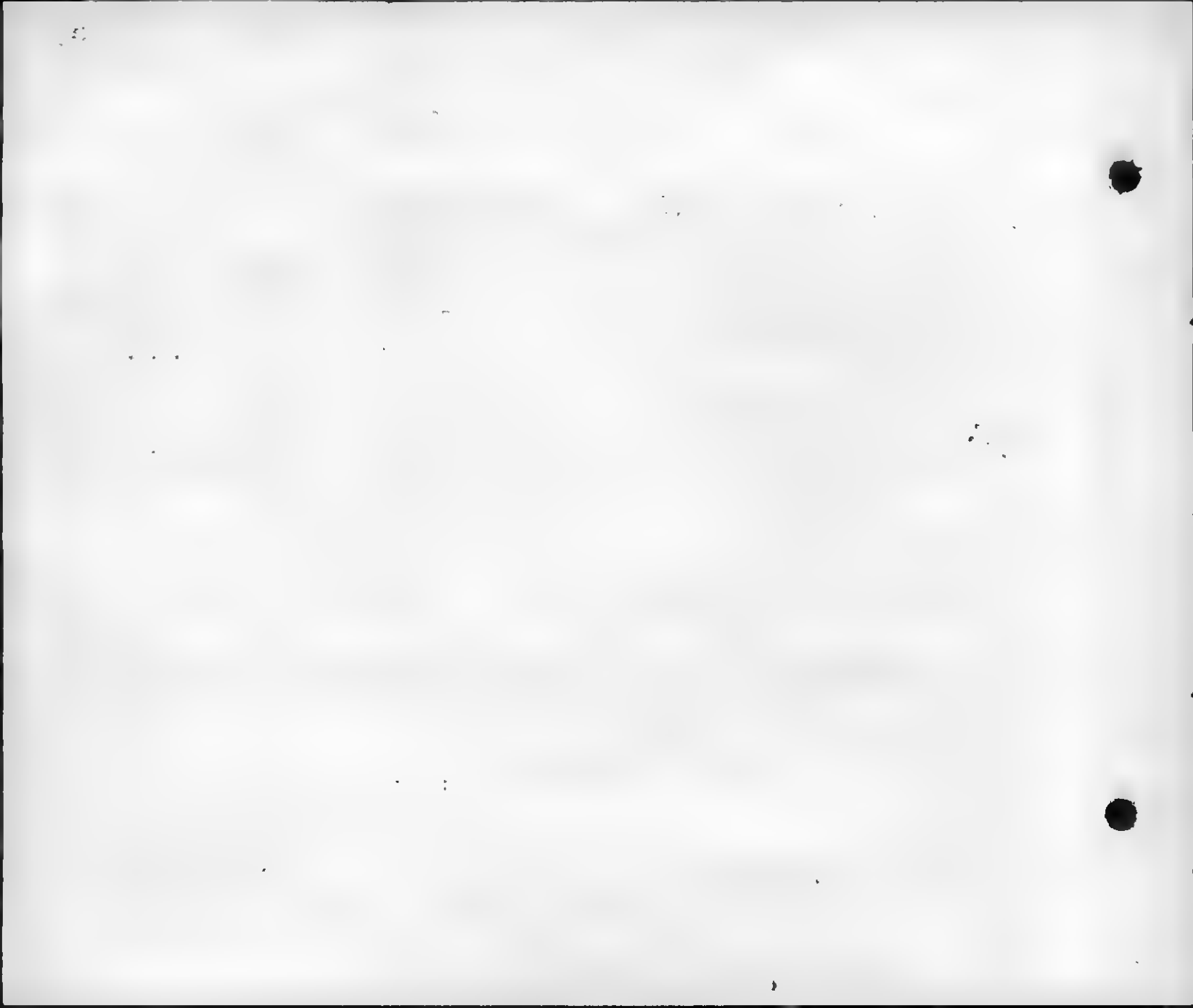
(Store)  
Co., Pa.

24b. REGISTRAR'S SIGNATURE

DATE JAN 16 '59

Children of the

VS A15 (4)  
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Va.</b> c. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Amer</b> Last <b>Suter</b>				4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1866</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>92</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Amer Suter</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Walker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>20 W. College</b> <b>Charles Amer Suter Jr. Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>None</b> DUE TO (c) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/17/54</b> 19 <b>54</b> to <b>1/18/59</b> 19 <b>59</b> that I last saw the deceased alive on <b>1/18/59</b> 19 <b>59</b> and that death occurred at <b>4:45AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b> DATE SIGNED <b>1/19/59</b>							
ACTUAL SIGNATURE <b>Martin M. Rothstein M.D.</b>		PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein M.D.</b>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Piedmont, W. Va.</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



60  
CERTIFICATE OF DEATH

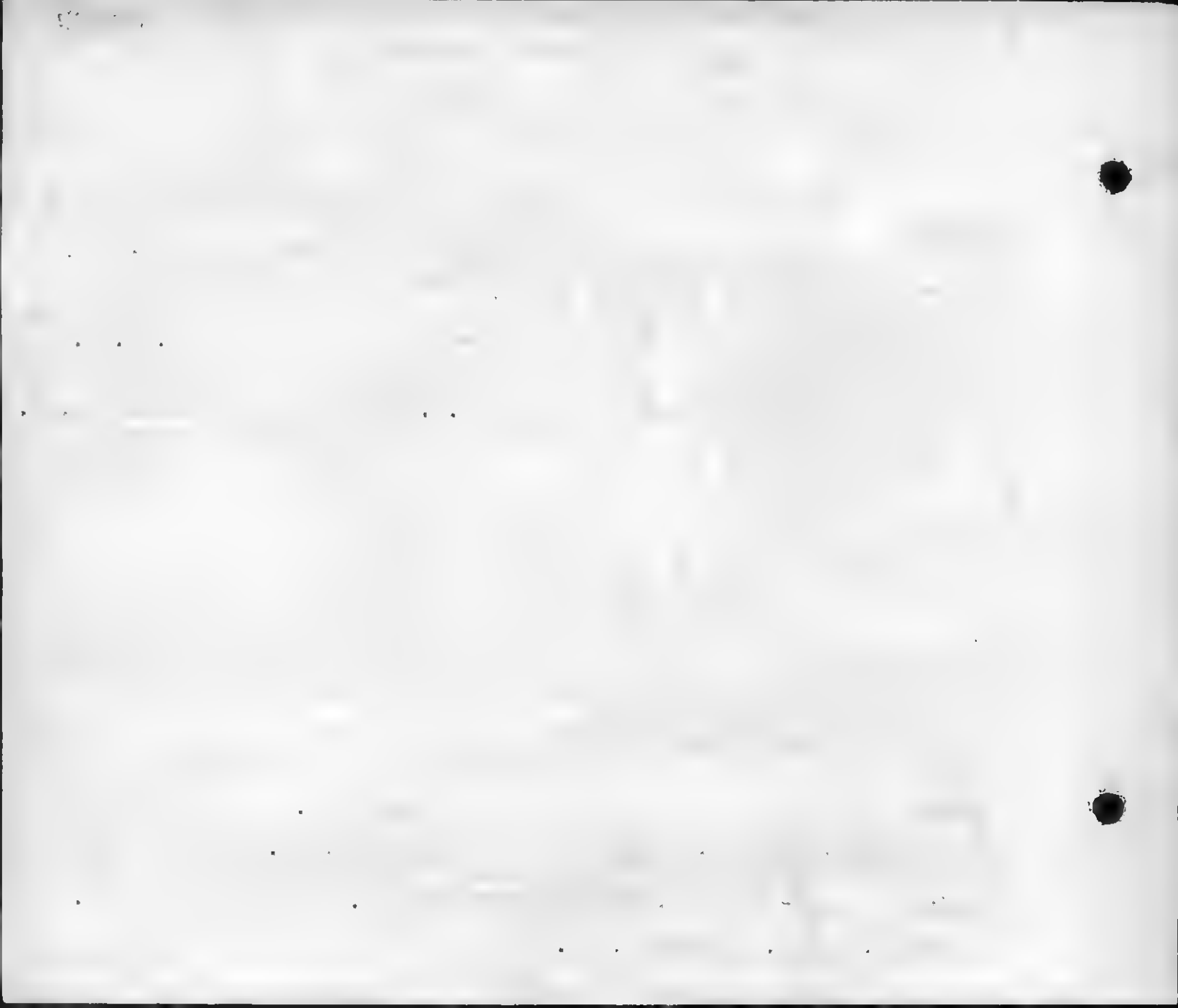
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN IB <b>8/12/54</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>72 West Main Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Trimble</b>				4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/7/1866</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James Findlay</b>				14. MOTHER'S MAIDEN NAME <b>Roseanna Reed</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial degeneration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis,</b> DUE TO (c) <b>Senile deterioration.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephritis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>8/12/54</b> , 19__ to <b>1/9/59</b> , 19__, that I last saw the deceased alive on <b>1/9/59</b> , 19__, and that death occurred at <b>6:45 P</b> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.				ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>1/10/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				<b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1-12-59</b>		<b>St. George's Cemetery</b>		<b>Mt. Savage, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>J. R. Durst</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

00093

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL AND WARWICK AVES.		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) DELPHIA First Middle E Last WAGONER		4. DATE OF DEATH Month JANUARY Day 9, Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 27 1902
9. AGE (In years last birthday) 58 56 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WELLINGTON LANDIS		14. MOTHER'S MAIDEN NAME MAHELIA HEDRICKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO —	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]			
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Renal Failure 5 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrotic Syndrome 12 y (c) Malignant nephrosclerosis 12 y			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Essential Hypertension 12 y			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 59 to Jan 19 59, that I last saw the deceased alive on Jan 19 59, and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S G WEISMAN M.D.		ADDRESS (Street, city or town, state) 59 Enoch St Cumberland Md	
DATE SIGNED 1/11/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		22d. LOCATION (City, town, or county) (State) Fort Ashby W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc. Cumb. Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 13 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 86 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY All <i>any</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a STATE Maryland b COUNTY All <i>any</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First PATIENCE Middle MARGARET Last WENCK		4. DATE OF DEATH January 4 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1900
9 AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME George Arnold		14. MOTHER'S MAIDEN NAME Lily Atkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. none	
17. INFORMANT Frank Wenck, Frostburg, Rt. 2, Id.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Cardiovascular DUE TO (c) Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1957, to Jan 4, 1959, that I last saw the deceased alive on Jan 4, 1959, and that death occurred at 12:45 PM from the causes and on the date stated above			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 Broadway, DATE SIGNED	
PHYSICIAN'S NAME (Type) John L. Davis, M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-59	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



100

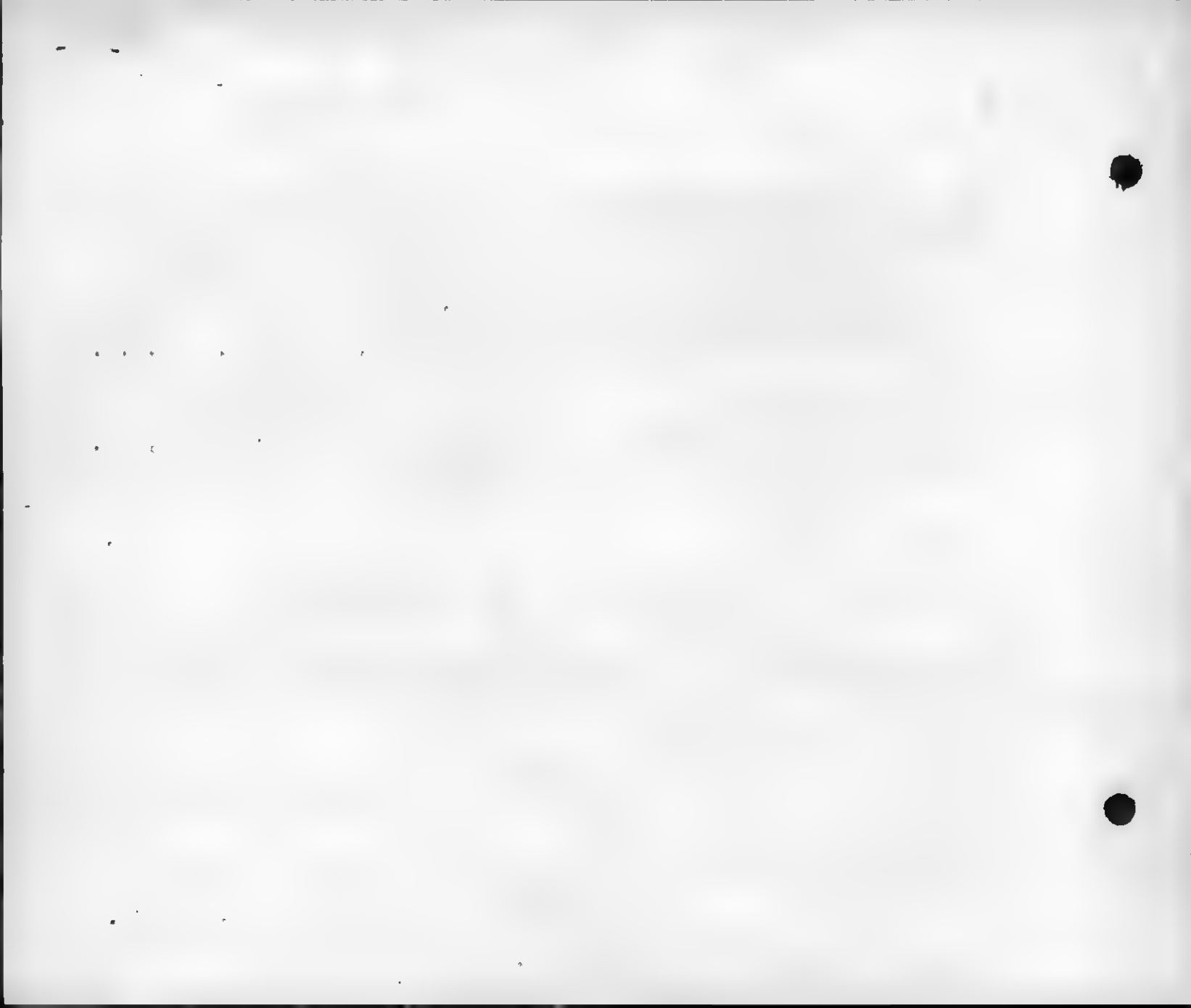
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Watercliffe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Althea</b> First Middle Last		4. DATE OF DEATH <b>January 8 19 59</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Park</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>"Brother"</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Congestive Heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 19 58</b> to <b>Jan 19 59</b> that I last saw the deceased alive on <b>Jan. 3 1959</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN ST</b> DATE SIGNED <b>JAN. 9 1959</b>			
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR. M.D. LONAICONING MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 12 59</b>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>21 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Richard</b>		First <b>Bray</b>		Middle <b>Wilson</b>		Last		4. DATE OF DEATH <b>Jan</b>		Month <b>16</b>		Day		Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1937</b>		9. AGE (In years, last birthday) <b>21</b> yrs		IF UNDER 1 YEAR Months <b>21</b> Days <b>16</b>		IF UNDER 24 HRS Hours <b>16</b> Min <b>59</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>				11. BIRTHPLACE (State or foreign country) <b>Lnaconing, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James P. Wilson</b>								14. MOTHER'S MAIDEN NAME <b>Pearl Bray</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-34-7893</b>				17. INFORMANT <b>Mr. James P. Wilson, Barton, Md.</b>								Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lacerated Brain</b>																			
*24x DUE TO <b>Fracture Left Frontal Skull</b>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Left Occipital Skull</b>																			
(c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Automobile accident - Thrown from car onto rock in creek</b>																			
20c. TIME OF INJURY Month, Day, Year <b>Hour 10:00 a.m. Jun 16 1959</b>																			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>																			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Public Highway</b>																			
20f. (City or town) <b>Barton</b> (County) <b>Allegany</b> (State) <b>Md</b>																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>W. C. H. Hine</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																			
EXAMINER'S NAME (Type) <b>W. C. H. Hine</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
DATE SIGNED <b>Jan 17 1959</b>																			
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Jan. 19, 1959</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Beal</b>								ADDRESS <b>Westernport, Md.</b>				24a. REC'D BY REGISTRAR <b>DAWAN 19 59</b>				24b. REGISTRAR'S SIGNATURE <b>W. C. H. Hine</b>			



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>216 Wallace ST</u>				c. LENGTH OF STAY IN 1b <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 Wallace ST.</u>				d. STREET ADDRESS <u>216 Wallace ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Nelson Wood</u>				4. DATE OF DEATH Month Day Year <u>Jan. 22 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1899</u>	
9. AGE (in years last birthday) yrs. <u>59</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>22 19 59</u>		IF UNDER 24 HRS. Months Days Hours Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bell Hop</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Wood</u>				14. MOTHER'S MAIDEN NAME <u>Mae Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) <u>Yes W.W.I.</u>				16. SOCIAL SECURITY NO. <u>W.W.I.</u>		17. INFORMANT Address <u>Mrs Wm N. Wood Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renalized Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 15, 1958</u> , to <u>Jan 21, 1959</u> , that I last saw the deceased alive on <u>Jan 20, 1959</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. M. Schirrdler</u> M.D.				ADDRESS (Street, city or town, state) <u>43 Greenleaf Cumberland Md</u>			
DATE SIGNED <u>1-23-59</u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

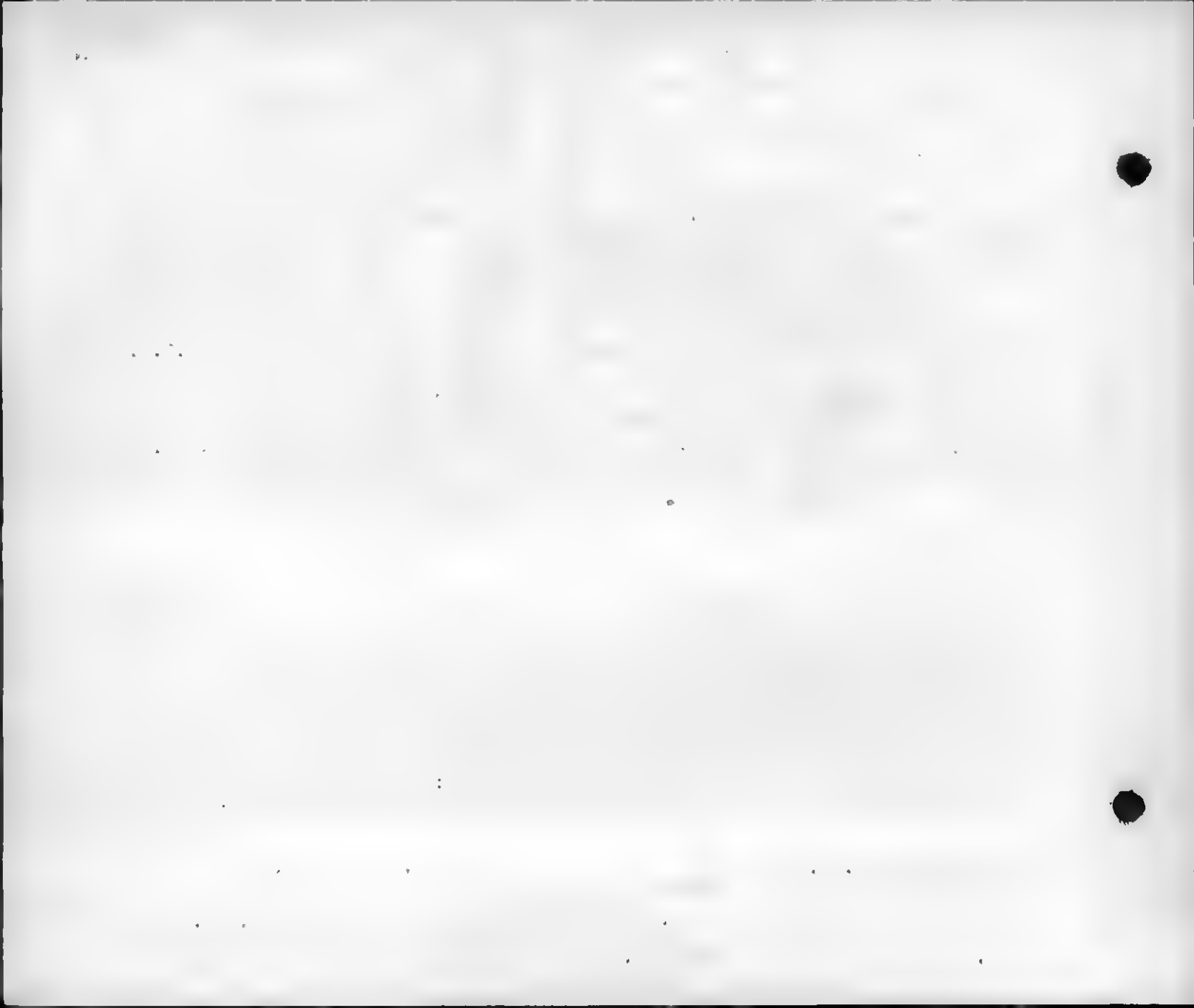
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63

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALEEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>22 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.</b>				e. STREET ADDRESS <b>64 GREENE STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>Angela</b> Last <b>YEAGER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 16, 1904</b>	
9. AGE (In years last birthday) <b>54</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Womens apparel</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. FATHER'S NAME <b>JOHN Egan</b>				13. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
14. MOTHER'S MAIDEN NAME <b>MARY O'DONNELL</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			
16. SOCIAL SECURITY NO. <b>213-22-3993</b>				17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident due to</b> <b>455.1</b> DUE TO <b>Encephalitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Fibriation</b> DUE TO (c) <b>Since Aug. 18, 1958</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 18, 1958</b> to <b>1-6-1959</b> , that I last saw the deceased alive on <b>1-5-1959</b> , and that death occurred at <b>8:10 A.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>1-7-59</b>			
PHYSICIAN'S NAME (Type) <b>W. F. WILLIAMS</b>				122 So. Centre St.,			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



## 64 CERTIFICATE OF DEATH

00099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Mae</b> Last <b>Yonker</b>		4. DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/91</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leonard Carneal</b>		14. MOTHER'S MAIDEN NAME <b>Elmaria Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Patient's Chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident (embolus)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Myocardial Fibrosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 30, 19 58</b> to <b>January 17, 19 59</b> , that I last saw the deceased alive on <b>January 16, 19 59</b> , and that death occurred at <b>2:10 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel M. Jacobson, M.D.</b>		ADDRESS (Street, city or town, state) <b>50 Pershing Street</b>	
PHYSICIAN'S NAME (Type) <b>R.W. Ballin, M.D.</b>		DATE SIGNED <b>1/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.20.59</b>	
22c. NAME OF CEMETERY OR CREMATION <b>Piney Plains</b>		22d. LOCATION (City, town, or county) (State) <b>Little Orleans Allegany Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Lane</b>		ADDRESS <b>Hancock Md</b>	
24a. REC'D BY REGISTRAR <b>JAN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained while hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

00100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>16 HRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>L</b> Last <b>ZIMERLA</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 5, 1893</b>	
9. AGE (In years last birthday) yrs. <b>65</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Auto Body Repair Self.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland Md</b>	
13. FATHER'S NAME <b>WILLIAM ZIMERLA</b>				14. MOTHER'S MAIDEN NAME <b>Lula Weber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year and address of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>217-30-1768</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Obstruction</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/2</b> , 19 <b>59</b> , to <b>1/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/3</b> , 19 <b>59</b> , and that death occurred at <b>2:12 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George M. Simons</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>1/4/59</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE M. SIMONS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/5/59</b>		<b>Wilkeson Burial Park</b>		<b>Cumb Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b> ADDRESS <b>Cumb Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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10-1-1911

10-1-1911

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Physician	